ANGLIA RUSKIN UNIVERSITY

SAFEGUARDING CHILDREN?
CHILD RECORDS IN ACCIDENT AND EMERGENCY
THE PERSPECTIVES OF STAFF

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A Thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Doctor of Philosophy

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Thank you

In memory

Victoria Adjo Climbié: Born November 1991 – Died February 2000
Peter Connelly: Born March 2006 – Died August 2007

ANGLIA RUSKIN UNIVERSITY

ABSTRACT

FACULTY OF HEALTH AND SOCIAL CARE

DOCTOR OF PHILOSOPHY

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BY JOYCE AGATHA FORGE
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This case study of the use of hospital accident and emergency records to safeguard children was triggered by Lord Laming's inquiry into the care of Victoria Climbié, his follow up report, and government legislation since 1948. Research on the use of documentation for safeguarding children is limited, although serious case reviews consistently indicate, that across agencies, record keeping, and the sharing of pertinent information to identify patterns of maltreatment is poor. The social constructed meaning people place on hospital documentation relating to children's safety and the perceived intentions of conveying that information within and between social environments are the focus of this research.

A hermeneutic framework was used to identify how staff in A&E and other agencies perceive the use of A&E child records (birth -16 years). The investigation was in three stages (a) analysis of a purposive sample of 378 A&E children's records, (b) a focus group with twelve A&E staff on the case study site and (c) another group with twelve members of the Local Operational Child Protection group. Colaizzi's approach and the hermeneutic circle were the methods utilised to provide a rich description of the essential structure of the phenomenon.

The results reveal that although written records are good tools for communication, records are not sufficiently child focused and risks factors are not always recognised. Consequently, the ability of the professional to provide information to safeguard children is limited. The data also highlights professional communication as the central theme, because this seemed to describe and unify the participants' practices in a way that made sense.

The findings of this study indicate that the behaviour of staff plays a crucial role in recording information. They are influenced by factors that are multi-faceted with the complexities of meanings that include social, economic, emotional, cultural, political and technical elements. A new theoretical framework to understand the complex interaction of professional perspectives within the varied situations that occur in clinical practice is proposed. This is underpinned by a constructivist epistemology. This provides an efficient method for evaluating the overall behaviour of the major components that affect documentation and communication, and highlights the recurring problems that arise from these areas when safeguarding children. Hence, this study provides an original contribution to knowledge concerning information sharing in the field of child protection. As a result of the findings of this study A&E records have been redesigned locally.

Key words
Safeguarding children, information sharing, child records, accident and emergency.

ACRONYMS

ACPC - Child Protection Committee

CYPU - Children and Young Persons' Unit.

DfE - Department for Education.

DfES - Department for Education and Skills.

DH - Department of Health.

DH et al - Department of Health, Department of Education and Employment.

DH and DfES - Department of Health and Department for Education and Skills.

DHSS - Department of Health and Social Security.

LA - Local Authority

LACPT - Local Authority Child Protection Team

LOCP - Local Operational Child Protection Group, these are representatives from other agencies who work outside of the hospital environment.

LSCB - Local Safeguarding Children Board.

MAPPA - Multi Agency Public Protection Arrangement

MAPPS - Multi Agency Public Protection Panel

RCoP - Royal College of Physicians**.**

RoSPA - Royal Society for the Prevention of Accidents

RCPCH - Royal College of Paediatrics and Child Health.

JCI - Joint Chief Inspector

WTSC - Working Together to Safeguard Children document.

Glossary of Terms

A&E - accident and emergency department. **ED** - Emergency department. For consistency throughout this study the term A&E will refer to the A&E department, because in some hospitals it may be referred to as the ED.

Cause for concern - refers to the records of any child who attended A&E and who needed support from services such as health visitors, school health advisors and/or social care.

Child - refers to those aged between birth - 16 years. The age range is equivalent to the years of statutory support by the health visiting and school nursing service. This age range fits in with the role and responsibilities of a Paediatric Liaison Health Visitor. Those over 16 are more independent and are legally entitled to make decisions about treatment and care. This is also the point at which some may start to transfer to adult services.

Child Records - when a child attends A&E, a record, completed with personal details, a description of the injury, how it occurred, and the course of action taken is defined as A&E child records.

Child Protection - is part of safeguarding and promoting welfare. This refers to activity which is undertaken to protect specific children who are suffering, or at risk of suffering, from significant harm. Defined as in the guidance of the Working Together to Safeguard Children Document (HM Government 2006:1.20 p.5)

Considered to be at risk - refers to any child and their family, who attend the A&E department on the case study site, who need continuing support from services involved in the care of children (for example, health visitors, school health advisors, and social care).

Clinical Audit - previously known as medical audit until a name change in the early 1990's, it is a quality improvement process that involves reviewing the

delivery of healthcare to ensure that best practice is being carried out, and was introduced to the NHS by the 1989 White Paper Working for Patients.

Diverse professionals - refer to all members of staff who share the information contained in A&E child records (colleagues from health and social care environment).

Local Authorities - Defined as in the glossary of Working Together to Safeguard Children (DH,2006). Local Authorities generally means authorities in Children Services effectively responsible for social services and education. Section 63 of the Children Act 2004 defines Children's Services in England as: a county council in England; a metropolitan district council; a non-metropolitan district council for an area where there is a county council; a London borough council and the Common Council of the City of London.

Paediatric Liaison Health Visitor (PLHV) - In the context of this research the PLHV is the community's nursing link that brings the primary health care team and other health care teams together. The Accident & Emergency Services for children: Royal College of Paediatrics and Child Health (RCPCH) multidisciplinary Working Party report (1999) states that**:**

*"The employment of a liaison health visitor aids communication at the interface between A&E, in-patient services and primary care, and facilitates notification to family health visitors of the attendance of all children under five years, and to the school nursing service for 5-16 year olds. The latter aids appropriate targeting of health promotion activities and action on injury as highlighted by the recent Green and White papers, as well as any child protection issues" (*Recommendation 10.4, page 19, paragraph 5).

The Laming report (2003) states:

"Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm" (Recommendation 90, paragraph, 12. 57).

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SAFEGUARDING CHILDREN?
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JOYCE AGATHA FORGE

Introduction

"Baby Peter's horrifying death could have been prevented. If the principles and approaches described in this report had been applied by the four protecting professions, the situation would have been stopped in its tracks" (Executive Summary-LSCB, 2009, p.25, paragraph 5.7).

The above view expressed by the Local Safeguarding Children Board (LSCB) is from the Serious Case Review of Peter Connelly following his death in 2007. In reviewing this case, the LSCB (2009) was dismayed that the agencies (ie. hospitals, community trusts, social care services, police) responsible for Peter's care had failed to communicate efficiently as their responses were not sufficiently effective to protect him. The key issues here do not lie exclusively in the professionals' capability to collect the required information, but also in their proficiency to interpret it accurately. As a result the agencies (hospitals, community trusts, social care, and police) involved were unable to communicate coherent documentation as a necessity. Hence the LSCB's (2009) conclusion was that in a case which reflected the highest level of concern for a child's welfare there was a failure to communicate the true position.

This thesis is a case study which considers recording in the child protection process in England and the issue of documentation including the publication of serious errors over many years following the death of each child. It explores the use of child records in a hospital's Accident and Emergency Department (A&E[1]) as a means of improving child protection from the perspective of the staff that use these records. (The main research question below which leads to sub questions is discussed in Chapter 1).

Research question: In order to safeguard children how do staff in A&E and other agencies perceive the use of A&E child records (birth -16 years)?

Child protection is part of the safeguarding process where it is necessary to intervene when there is a reasonable belief that a child is at risk of harm (DfES,

[1]For consistency the term A&E department will be referred to as A&E throughout this study, because in some hospitals it may be referred to as the Emergency Department (ED). See page iv above for other acronyms.

2004a). In the UK, there are no compulsory reporting laws, but there is guidance for practitioners which is issued by professional bodies and local safeguarding children boards. The guidance emphasises the need to make a referral where there is a reasonable belief that a child is at risk. For members of the public, if they have a concern about the welfare of a child, they should report their concerns to their Local Authority Child Protection Team (LACPT), the National Society for the Prevention of Cruelty to Children (NSPCC) helpline, or the police. These telephone numbers, including an out-of-hours contact, should be publicly available. Once the LACPT receives a referral, they must decide within 24 hours what action is to be taken. The Local Authority (LA) has the duty to investigate concerns about any child who is physically present in their area, even if the child is a resident of a different LA. Customarily social workers are responsible for undertaking the investigation and initial assessment of the child's needs. So they would meet with the child and family members and also liaise with other professionals who know the family (such as teachers, health visitors, police and doctors) in order to gain appropriate information, as a result most of the above professionals/agencies can be involved following an A&E assessment.

Government documents (DH, 2004a; HM Government, 2010) emphasise that information sharing is vital to safeguarding and promoting the welfare of children and young people. It is also essential to enable early intervention to help children, young people and families who need additional remedial services to achieve positive outcomes, thus reducing inequalities. Many of the key messages from Serious Case Reviews (Laming, 2003; 2009; DH, 2004a; LSCB, 2009) identified that the lack of emphasis on the child diverted attention from an appropriate assessment of the child's needs. Consequently the approach to safeguard children that is only possible through accurate information sharing is impeded.

Shortcomings in children's welfare services were brought into the spotlight with the death of Victoria Climbié, the subsequent public inquiry and Laming's follow-up reports (2003; 2009). Laming (2003) argues that identifying those children with the greatest need of protection was a particular issue for A&E departments due to poor record keeping and information sharing.

Contributions from a large number of disciplinary perspectives, including health and social care, law enforcement, sociology, business policy, economics, public policy, politics and management have been made to assist analysis of this issue (detailed in Chapter 2). It is specifically identified that the flow of information between professionals on the basis of patient's documentation is considered to be poor (Laming, 2003; 2009; LSCB, 2009).

In the socially constructed world of reality (Berger and Luckmann 1967), man in society produces a world of objects. Berger and Luckmann (1967), claim that all objects have meaning and that meaning is a product of communication between people. However, while a written or electronic record has an object reality, since they actually exist and can be seen, it is the meaning of the function of the documentary record to staff, the social construction placed on documentation, regarding intentions of conveying that information, that is the focus of this study. The basis of the study was to identify and understand how staff in an A&E environment perceive their roles in the selection, recording, and communication of information to other colleagues. Therefore a phenomenological approach is utilised to explore the following phenomenon: the use of child records in one hospital's Accident and Emergency Department (A&E) from the perspective of the staff that use these records. Phenomenology (see Chapter 5) is an approach that is concerned with the lived experience (Denzin and Lincoln, 2005).

Developing knowledge about the social constructions that people have regarding documentation in relation to safeguarding children is important to encourage effective communication. People are not always aware of how documentation and information sharing has been received by others and the importance of this in providing an effective integrated service. By using a social constructivist approach from the perspective of the staff that use A&E records, the research draws attention to the gaps in understanding of the function of documentation to inter-professional communication. Successful collaborative working is understood to be the key that enables early intervention to help children at risk (HM Government, 2010).

Thesis structure

This thesis is organised in ten chapters.

Chapter 1 provides a background to processes of documentation in child protection and gives a rationale for the study.

Chapter 2 provides a critical evaluation of relevant literature and is carried out in two parts: a review of pertinent research papers and a discussion of issues relating to communication.

Chapter 3 analyses government legislation, policy documents and the unresolved issues in child protection. It also presents a critical evaluation of the child protection process as a case study.

Chapter 4 examines the social constructionist conceptual issues and the conceptual approach that inform this study. It provides a theoretical approach to understanding the social construction of documentation in the child protection arena and how information sharing can be understood between colleagues in a health and social environment.

Chapter 5 outlines a methodological approach and the methods used to collect data used within the study.

Chapter 6 presents the findings of the fieldwork from all three stages of the study, and identifies significant issues regarding the content and accuracy of the records.

Chapter7 presents the data analysis of the study using a hermeneutic phenomenological framework. The evidence indicates possible reasons why ineffective documentation problems have not been addressed.

Chapter 8 discusses a new framework in relation to the evidence gained in the study.

Chapter 9 reviews the neglected area of documentation within research literature and discusses the significance of the study findings in this context.

Chapter 10 presents the contribution to knowledge, contribution to practice, strengths, and limitations of the study, recommendations for further research, and my reflective journey.

The use of the first and third person – in the thesis where my work is directly involved the first person is used; accordingly the third person is used when discussing work in other contexts.

Appendices - **Please note** that the appendices are laid out in the order in which the study was undertaken, for this reason in the body of the thesis they cannot be referred to sequentially.

Chapter 1 - The use of A&E Child Records

Introduction

This chapter presents the background policies that set standards for the generation of child assessment records in A&E which informs this evaluation of recording in practice, and which triggered my initial concerns regarding their implementation (see Chapter 3).

1.1. Background

In A&E, members of staff are front line providers of care responses to the needs of vulnerable children (Laming, 2003; 2009). Children are brought to A&E departments for assessment of a critical health problem which can indicate an accident, assault, or general neglect. Regular visits suggest the child is at persistent risk within the environment it is currently living. Both the (WTSC) Working Together to Safeguard Children document (HM Government, 2010), and Standard 5 of the National Service Framework (NSF) for Children (DH and DfES, 2004b) specify a care pathway through services such as A&E in order that children's rights and potential vulnerability are not overlooked.

The NSF (DH and DfES, 2004b) stipulates that in order to safeguard children, information needs to be brought together from various different sources and careful judgements made on the basis of this information. It further states that well-kept records provide the essential underpinning to good child protection practice. Good record keeping is not only an important part of the accountability of professionals to children, it can also help to focus work, prevent a disservice to children, and assist with the continuity of care. It is also stated in the NSF (DH and DfES, 2004b), that well-kept records are important for peer review as they provide essential tools for work to be monitored.

Overall, the principles of effective record keeping in both the NSF (DH and DfES, 2004b) and the WTSC documents (HM Government, 2010) advocate that records should be clear, concise, accessible, and comprehensive. These guidelines stipulate that judgements made, actions and decisions taken should be carefully recorded. Where decisions have been taken jointly across agencies, or endorsed by a manager, this should be made clear. They point out that relevant information about

a child, which leads to any intervention should include the history of the child, nature of any intervention including outcomes, the means by which change is to be achieved, and any progress that is being made. Thus, if information is to be shared effectively, records should be detailed, and they should be stored safely so that they can be retrieved promptly and efficiently. Record keeping is not only critical to the safeguarding of children; it is also a tool of professional practice, and an integral part of medical, nursing, midwifery and health visiting, because it underpins clinical practice and supports the care process (GMC, 2006; NMC, 2008).

The ethos behind the sharing of A&E records is to encourage partnership between multi-professionals and improve communication leading to enhanced continuity of care. This view is echoed in both Standard 5 of the NSF (DH and DfES, 2004b) and the WTSC document (HM Government, 2010). These national guidelines state that the welfare of children is of primary importance, because their age and vulnerability renders them potentially powerless to protect their own interests. The DH (2002) report has also stated that shared records have been found to be helpful in contributing to injury prevention and appropriate use of scarce resources.

Despite the fact that Saving Lives: Our Healthier Nation (DH, 2000a), made injury prevention a priority in the United Kingdom, unintentional injury is one of the leading causes of morbidity and mortality in children aged one to 14 years (Audit Commission and Healthcare Commission, 2007), and puts more children in hospital than any other cause (DCSF, 2009). It is recognised that many unintentional injuries are preventable (RoSPA, 2002). Both the WTSC document (HM Government, 2010) and the Laming (2003; 2009) reports expressed the view that in order for preventative action to be effective it must be coordinated across a variety of agencies and requires good record keeping.

Current legalisation closely informs policy-making in respect of the safeguarding of children by effective communication. As a result, a number of statutory instruments are involved, for example, the Children Act 1989, and the Children Act 2004 informs Every Child Matters (DH, 2004a), and the Working Together to Safeguard Children document (HM Government, 2010). Necessity for new legal and policy requirements were generated due to the effect and impact of recurring

child protection cases (Chapter 3)[2]. The emphasis within these requirements relates to revision and improvements on process issues, standardisation, protocols and procedures. These modifications effect changes in documentation formats and procedures.

The Laming reports (2003; 2009) especially draw attention to poor record keeping and information sharing as being particular challenges encountered by A&E departments when caring for children. Whilst acknowledging the importance of Laming's (2003; 2009) work, his recommendations echoed those of earlier reports, for example, the Curtis report (1946). The issues of documentation and information sharing is long-standing, and that the notion of safeguarding children through effective documentation remains a key government priority.

1.2. Rationale

The purpose of this study is to evaluate the use of child records in A&E as a means of improving child protection from the perspective of the staff that use these records in order to improve written documentation. My personal interest in this subject emanated from professional involvement as a PLHV together with my MSc study, which explored ways of improving services for children (Forge, 2006). In 2001 a critical incident occurred locally, whereby the records of a child were not available and therefore, the needs of the child who was considered to be at risk or vulnerable[3] were not met.

Following this incident, I reflected and considered whether this was an isolated incident or was there a genuine cause for concern? Therefore, a small study was conducted in December 2002, involving 15 participants from the A&E multi-professional team of an acute hospital in Essex. The study, at the time, asked why children's health and social care records would not be available to meet the needs of a critical incident concerning child protection. This local evaluation prompted fundamental questions about the functions of the sharing of child records in A&E,

[2] List of cases shown in **Appendix 29**

[3] The term vulnerable is used in this thesis consistent with the National Institute for Health and Clinical Excellence (NICE, 2010a) guidance and refers to those at greater than average risk of an unintentional injury due to one or more factors. For example, these factors could include the under fives, low income families, some ethnic minorities.

which led to this project. The issues in this study relate to meanings and truth concerning what happens in everyday life. For example:

- Problems in communication;
- Gaps in information sharing;
- The meanings and communication given about child protection;
- What is recorded in A&E records and the problems concerning the effect and impact of recurring child protection scandals on human behaviour.

1. 3. Research question

Consequently the main research question is:

In order to safeguard children how do staff in A&E and other agencies perceive the use of A&E child records (birth - 16 years)?

This leads to the following sub questions:

a) How does the use of A&E child records fit into the wider aims of safeguarding children?
b) To what extent do A&E staff and other agencies value and share A&E records to help safeguard children?
c) What knowledge is there of the purpose and use of A&E child records?
d) What evidence is available to show how and why A&E child records are actually used?
e) What are the implications for practice of the findings of this research?

The research question is based on the premise that staff perceptions, views, and understanding of the use of child records in A&E, may play an important and influential role in the safeguarding of children at risk. The accident and emergency department of an acute hospital in Essex was the focal point for this project. Due to the opportunities that this thesis allows, this research focuses only on the use of child records generated in an A&E department in one location. There is no provision for any further investigations concerning child records generated in other departments. The age range in this project (birth - 16 years) is in accordance with the specification of the role of the PLHV as identified by The Royal College of Paediatrics and Child Health Multidisciplinary Working Party report - Accident and Emergency Services for children (1999) and the Laming report (2003). By

choosing this age range, I do not mean to imply that the welfare of children over 16 are not considered. However, in this case the needs of 17 to 18 year olds are cared for by staff in the A&E department. Also those children over 16 are becoming more independent and are legally entitled to make decisions about treatment and care. This is also the point at which some transfer to adult services.

1.4 A&E Children attendances

For the purpose of illustration, it has been estimated, that in the United Kingdom there are 2 million child attendances each year to A&E (Audit Commission and Healthcare Commission, 2007; DCSF, 2009). Locally, records revealed that 63 children per day (and rising) is the average number of attendances to A&E which equates to 2646 annually. In order to clarify the position of the use of records locally **Figure 1.1** below is an illustration of the communication pathways of child records (see Chapter 5).

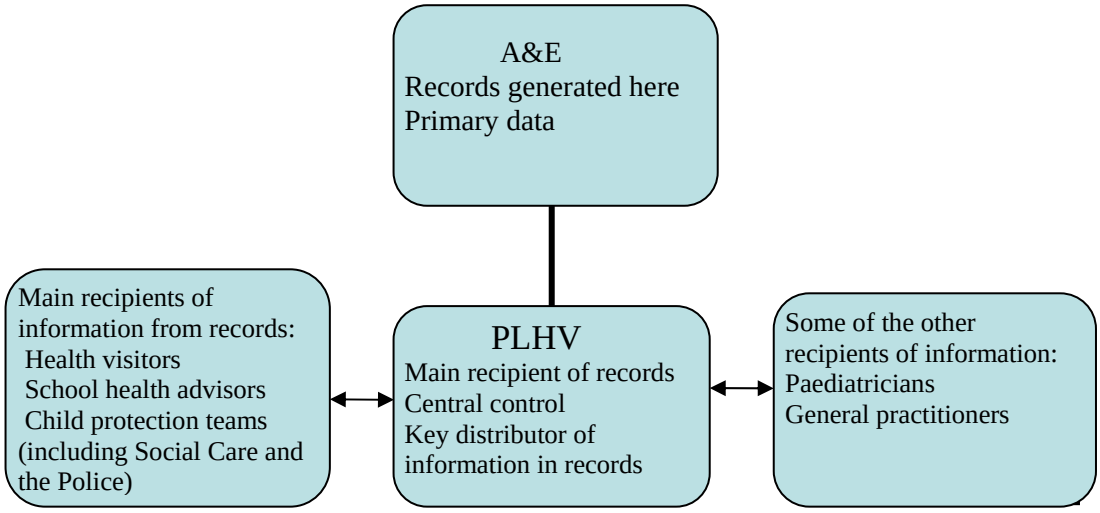


Figure 1.1 Communication pathways for A&E child records.

1.5 Gap in knowledge

There needs to be a greater focus on better information sharing within the developing area of safeguarding children which is driven by major legislation, policy and practice. However, the importance of human interpretation, such as staff value and perception of documentation is too infrequently given importance. It is the social construct that people give to record keeping which primarily influences the effectiveness of services. A key factor in many serious case reviews (Laming,

2003; 2009) has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect. Therefore, the purpose of this study was to explore how individual staff in one A&E department attribute meaning to observed behaviour and other data, and how this influences standard procedures for records. The flowchart in **Appendix 27** illustrates how these chapters are linked**.**

1.6 Conclusion

This chapter presents the overview to the study and sets the scene to safeguard children by means of documentation. To safeguard children, government guidelines (DH, 2004a) claim that sharing information is essential to protect children from suffering harm, abuse or neglect and to prevent them from offending.

The main focus that derived from public inquiries, major legislation, policy and practice appears to concentrate on process issues, standardisation, protocols and procedures (see for example, Laming, 2003; 2009; HM Government, 2010). It is acknowledged that these are of immense importance, since it is the robust and consistent implementation of these policies and procedures which keeps children safe (Laming, 2003; 2009; HM Government, 2010). Therefore, this study focuses on the social constructs of how the staff in A&E and other agencies perceive the use of A&E child records (the everyday life of an A&E community). This study is an attempt to address that knowledge gap.

In Chapter 2, pertinent research literature is identified and reviewed.

Chapter 2 Critical evaluation of pertinent literature

This chapter presents an overview of existing research of the problem being addressed, and is used to develop an argument that demonstrates the need for the study. It provides classification of the key ideas for the investigation from which a contribution to knowledge will be made. The review addresses two areas of research: firstly that which relates to pertinent literatures on the use of A&E child records: secondly, communication, as it is the overreaching factor in this project, and an overview of the importance of written communication is presented. Within the discussion is a review of the concept of information sharing in different contexts, including collaborative working, and some of the benefits, barriers and limitations of inter-professional working. This chapter concludes by drawing together the findings of the review.

2.1 Phase 1 of the literature review

2.1.1 *Purpose of the literature review*

Information sharing is vital to safeguarding and promoting the welfare of children and young people (DH, 2004a). It is essential in integrated working in order to enable early intervention to help children, young people and families who need additional services in relation to education, health, behaviour, parenting, or family support, thus ensuring that all children receive the services that are appropriate to their needs (HM Government, 2006; 2010). However, serious cases of failure to safeguard children have resulted in a series of Department of Health inquiries (Laming, 2003; 2009; DH, 2004a; LSCB, 2009). These have consistently indicated poor quality in the recording and the sharing of pertinent information across agencies in order to indicate patterns of neglect or maltreatment of children. A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.

Shortcomings in working to safeguard and promote children's welfare were brought into the spotlight with the death of Victoria Climbie, the subsequent Inquiry and Laming's follow up report (Laming, 2003; 2009). Laming (2003) argued that identifying those children with the greatest need of protection was a

particular issue for A&E departments. The effect and impact of recurring child protection cases continues (illustrated in **Appendix 29**).

2.2 Literature review methodology

This section outlines the selection criteria adopted for this review, and provide descriptions of the types of studies reviewed. The methodological foundations upon which the reviewed research rest are also discussed. The basic outcome of this study is the description of the experience of the use of A&E child records. The literature reviewed included small scale qualitative and quantitative studies; therefore there is considerable heterogeneity in terms of methodology for these studies. It is also inappropriate to use quantitative methods to pool data from individual studies since quantitative approaches to the analysis would also lack philosophical congruence with the focus of the work (Droogan and Song, 1996). Thus the review of the literature uses qualitative methods to explore the meanings, variations and perceptual experiences of phenomena, as it is seeking to capture their holistic or interconnected nature.

It has been argued by Schutz (1967) that interpretivists trace their roots back to phenomenology. Whilst in Colaizzi's (1978) opinion the aim of phenomenology is to produce a description of a phenomenon of everyday experience, in order to understand its essential structure. Divergent views on the best methods to use to conduct a phenomenological review have suggested that there is no clear consensus (Walters, 1995; Crotty, 1996; Paley, 2005; Solomon and Higgins, 2009). Solomon and Higgins (2009) imply that if the appearance of structures can be described, then it is possible to arrive at certainty or ultimate truth. Munhall (1989) observes that beginner researchers often require guidance on where to begin and how to execute tasks which frames thinking, when they are first exposed to employing phenomenological methods. It has also been suggested that despite the plethora of phenomenological nursing research studies that have been published in the last two decades, few have provided guidance for beginner researchers on how to undertake the process of critically reviewing the literature for a study (Walters, 1995; Crotty, 1996; Mackey, 2005; Paley, 2005). Consequently, a review process has been adapted to facilitate a systematic and rigorous approach of the literature for this study.

2.3 Inclusion /exclusion criteria

The inclusion criteria were papers specifically referring to safeguarding children, information sharing and A&E child records. The exclusion criteria were papers that did not explicitly refer to these terms.

2.4. Literature review process

The requirement in this study (**see Figure 2.1 below**) was to select books and articles considered to be key works and sources on information sharing, safeguarding children, communication, and documentation that were related to the use of A&E records.

Parameters - English publications 1991 through to 2012: All research relating to the use of A&E Child records: Format: Any, books, journal articles, reports, conference literature and official publications children birth -16 years.

Key words
Safeguarding children - child protection, paediatrics, infant/babies, children, child, childhood, adolescence, youth, and teenagers.

Information sharing - communication, confidentiality, ethics, inter-professional, collaboration, interagency, perceptions, experiences, government policy, guidelines.

Child records - records and record keeping, nursing records, documentation and nursing.

A&E - Accident and Emergency, Emergency department.

Terms - using terms And and OR to allow only the most relevant studies to be retrieved.

Scope of search/search term-safeguarding children, information sharing, communication, record keeping, nursing records, written documentation, case study, perceptions, inter-professional practice, experiences, community, interagency.

Figure 2.1 Literature search profile: research relating to use of A&E child records

In order to locate the relevant literature for this study (the use of A&E records) a process of three stages (see **Figure 2.3**) was undertaken, the first was to seek references through hand searching and the use of electronic databases in order to retrieve relevant abstracts and titles, the second was a detailed evaluation of

appropriate full text papers and the third was to select pertinent literature. The overall literature review process is shown in **Figure 2.3.**

2.4.1 *Hand searching*

Using journals and books from local libraries and academic sources, including the British Library.

International and national sources of literature were accessed and materials for the last 20 years written in the English language were selected. Information was identified from a wide range of research studies and theories across a number of disciplines relating to health and social care, areas of epidemiology, paediatrics, health services research, clinical psychology, education, law enforcement and the fire services. Published research reports, research papers, reviews and policy documents and practitioner based papers concerned with safeguarding children and the promotion of their welfare were evaluated. As a result 42 potentially appropriate papers relating to the use of A&E child records were retrieved. As the literature reviewed involved a broad spectrum of peripherally related studies, in order to develop a meaningful context, it was decided to strive for relevancy and quality rather than quantity in selecting the studies. The papers were then scrutinised, based on the abstract of each of the 42 papers it was then determined whether the references were appropriate to the study. From the 42 abstracts appraised, one paper was identified as being potentially pertinent to the use of A&E child records and 41 inappropriate papers were discarded. Once the relevant paper was selected the full text report was obtained and reviewed again.

2.4.2 *Computerised search*

Utilising CD-Rom databases, Google, Google Scholar and Anglia Ruskin University's Digital Library. These were chosen as they maintained multidisciplinary resource which offer integrated searching opportunities in several bibliographic databases (see **Figure 2.2)**.

Cochrane Systematic Reviews Medical Literature On-Line (MEDLINE) Cumulative Index to Nursing and Allied Health Literature (CINAHL) Applied Social Sciences Index and abstracts (ASSIA)	Institute for Scientific Information (ISI) Web of Knowledge Dissertation Abstracts Conference Papers Index Child data British Nursing Index

Figure 2.2 Databases searched

After the topic the use of A&E child records was typed into the computer, from the initial feedback there were 155 matches in the databases. In order to ensure that only the most appropriate references were retrieved the search was limited to inclusion/exclusion criteria (see 2.3). This narrowing of the search reduced the initial 155 references on the use of A&E records to 12 papers potentially relevant for the study, 143 inappropriate references were then excluded. Next the papers that were applicable were viewed on the computer monitor, based on the abstract of each report it was then decided whether the paper was pertinent to the study. Subsequently, those papers that were identified as being relevant, full bibliographic information was printed, full research reports were obtained and they were reviewed again.

2.5 Detailed evaluation of literature

At this stage thirteen full text papers representing twelve research studies and one overview of literature which were identified and met the criteria (see **2.3 inclusion /exclusion criteria**) were evaluated again (see stage 2, **Figure 2.3**). The processes used to analyse the literature in this study has been adapted from (a) the method of phenomenology used by Colazzi (1978), (b) strategies by Hart (1998) and (c) principles from the hermeneutic circle (Heidegger, 1962), focusing on qualitative analysis methods (see **Figure 2.4)**

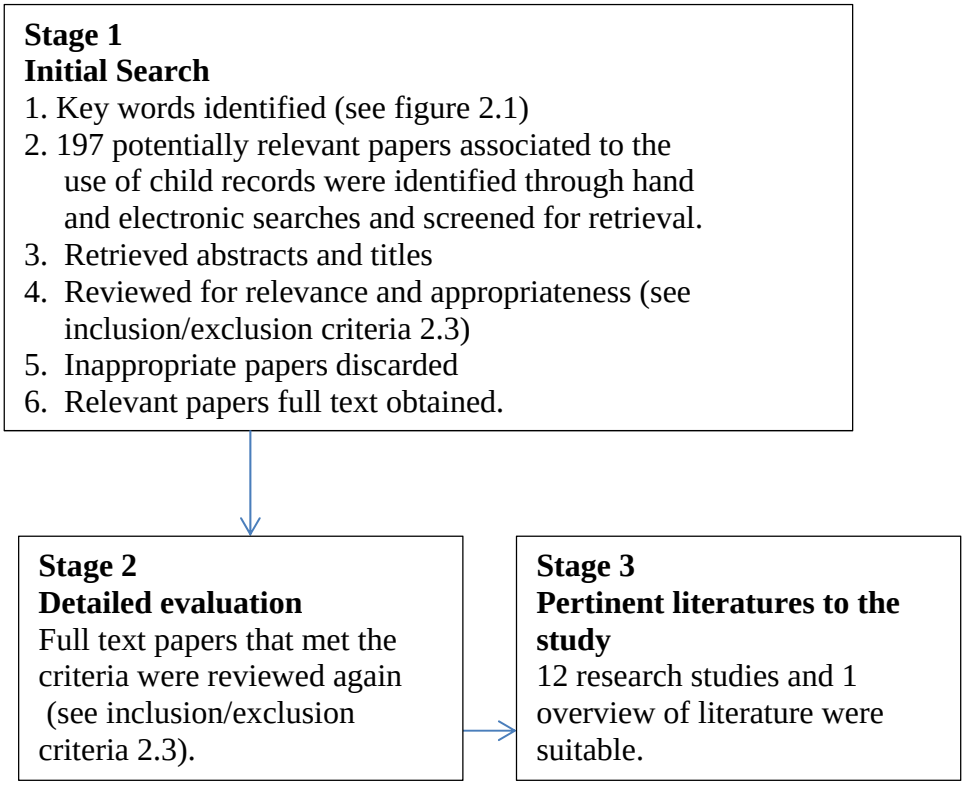


Figure 2.3 Flow chart overall literature review process

It is important to ensure that methodological suitability of the chosen framework befits the philosophical assumptions underpinning this particular research approach, as this influences the way in which the research study is conducted (Habermas, 1978; Berger and Luckman, 1979; Guba, 1990; Searle, 1995; Denzin and Lincoln, 2005; Polit & Beck, 2008). Colaizzi's (1978) hermeneutic phenomenological approach, a qualitative design, was utilised to guide the analysis of the literature. The framework offered a unified view of objective and subjective realities and involves seven procedural steps (discussed in Chapter 5). This method enabled the researcher to examine more effectively the complexities of communication when different professionals share the information contained in the records. Furthermore, as the researcher is in an environment where personal experience is social, in that event, the study of others' experiences occurs within the least explicit context of the researcher's own comprehension and understanding. According to Colaizzi (1978) other people's reports and descriptions can be used to gather data from a plurality of subjects to be reflectively analysed.

The work of Hart (1998) provided strategies and various techniques, which facilitated the systematic and critical analysis of each paper evaluated in the study and suggested that the criteria for a sound argument were:-

- Structure - use a reliable structure that is explicit following proper argumentation.
- Definition - define the terms you will use carefully with clear examples and backed by quality peer reviewed sources.
- Reasons - provide reasons for everything you have included as support.
- Assumptions - use only reliable assumptions that are free from subjective judgement and are based on valid reasoning.
- Evidence - use only reliable documented evidence from quality peer review sources that is legitimate and relevant.
- Fallacies - avoid fallacies, such as generalisations, abstractions and misplaced concreteness.

In essence the analysis entails identifying why the information being presented is of importance (Hart, 1998). Therefore a vigorous process and techniques of analysis for synthesizing the finding of the review was provided, thus enabling the researcher to identify ideas in the body of the literature, in order to arrange and structure arguments.

In addition, the hermeneutic approach was utilised (see Chapter 5). The hermeneutic circle (Heidegger, 1962) guides the hermeneutic approach, thus this process of analysis provides continual movement between understanding the parts and the whole of the document being appraised (Klein and Myers, 1999). This principal allows the development of shared meanings between the researcher and the subject to be comprehensive. The principles that may help assure rigorous interpretive analysis involved:

- Understanding the subject according to its social and historical context.
- Assessing the historical social construction between the researcher and the subject.
- Being aware of possible multiple interpretations among participants for a given sequence of events.

- Being conscious of potential biases or systematic distortions in the subject's narratives (Klein and Myers, 1999).

By combining all three of the above, a framework was provided (shown below in **Figure 2.4**), which facilitated the systematic critical analysis of each paper, thereby offering a vigorous process for integrating the findings of the review. Thus ensuring that the literature review is reported accurately, the validity is assessed, areas of agreement between research findings are identified and bias is avoided.

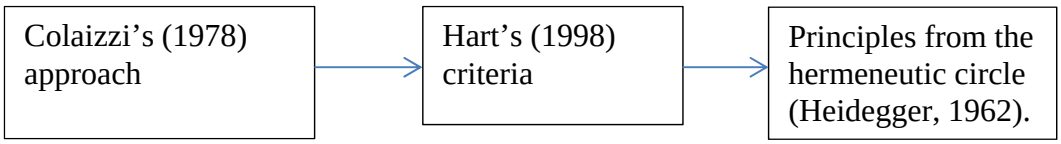


Figure 2.4 Framework used to review literature critically

2.6 Findings of the review

The abstracts and titles of one hundred and ninety seven papers that were potentially relevant to the study of the use of A&E child records (see **Figure 2.3**) were reviewed. One hundred and eighty-four studies did not fit the inclusion criteria and were excluded. Next, full text papers for the twelve research studies and one overview of literature that matched the inclusion criteria were obtained and were reviewed again. Based on the thirteen papers appraised it was then decided that twelve research studies and one overview of literature were appropriate for the study (see stage 3, **Figure 2.3).**

Gilbert et al. (2009), MacMillan et al. (2009) and Reading et al. (2009) in a series of four papers critically analysed evidence relating to child maltreatment with the aim of informing policy and practice in the United Kingdom. The study focused on high income and Eastern European countries that are in economic transition, since the problems and systems for response differed in low income and many middle income countries. In the first paper the aim was to quantify the importance of the issue, its determinants, and consequences. The second paper charted the evidence underpinning recognition and response by professional agencies dealing with children. Professionals in child health, primary care, mental health, schools, social services, and law enforcement all contributed to the recognition of and response to child maltreatment. In this paper evidence for under-recognition and under-

response suggested that officially recognised maltreatment statistics substantially underestimated the annual prevalence of maltreatment based on self-reports in community surveys and implied that this discrepancy could indicate failures to recognise and report maltreatment. This report also revealed that there is direct evidence from a number of studies that in all sectors (child health, primary care, mental health, schools, social services, and law enforcement), children suspected of being maltreated were under-reported to child protection agencies. The third paper assessed what works for prevention of child maltreatment and associated impairment, and the final paper discusses how consideration of children's rights could enable a more coherent effective approach. The flexibility and broadness of the scope and versatility of clinicians involved in the study meant that a great deal of information was gathered. The data was collected from a number of different studies and the descriptive account largely covered child maltreatment. The study demonstrated international comparisons (United Kingdom, New Zealand, United States of America, Canada, Australia and most European countries). This study appeared to have been designed to open discussion about recognising and responding to child maltreatment, and the authors appropriately expressed concern that professionals failed to report suspected child abuse. Nonetheless, the factors important to written documentation and information sharing were not identified or discussed, although the study did mention briefly that in some settings, recording of episodes of maltreatment was inadequate, because the history did not offer sufficient information to determine if there was a cause for concern.

Luderer and Behrens (2008) evaluated the flow of information between doctors and nurses on the basis of patient documentation in two German hospitals. The data was generated by examination of documentary evidence of a sample size of 145. Participants were adult patients with suspected or diagnosed lung cancer. The researchers used the Glaser and Strauss (1967) approach. This approach allowed the researchers to develop an inductive theory that was relevant to inter-professional documentation relating to the effects of time spent in the communication of information to lung cancer patients regarding their status. The authors acknowledged that, although this study shows how it is possible for patients with lung cancer to exchange information with health care professionals,

the result is limited for showing an effect on documentation and identifying really good communication.

Carter et al. (2007) audited nursing documentation in an accident and emergency department in South Africa, over a 5-week period. Files of adult patients admitted to the wards via the accident and emergency department in the preceding 24 hours were audited on a random basis. The results revealed that record keeping was poor. Carter et al. (2007) described their study as an audit, since the research evaluated documentation to establish base line data in order to introduce an early warning scoring system to monitor deterioration in a patient's condition. However, this audit could equally have been used in an exercise based on needs assessment, for it could have identified necessary tasks and additional resources required to improve A&E patient care.

Mc Fetridge et al. (2007) investigated an ethnographic study exploring the transfer of information between nurses from emergency departments (A&E) and critical care units (ICU). Participants, totalling 12, were nurses from the A&E and ICU of two acute hospitals in Northern Ireland. The data was collected through a multi-method approach, combining documentation review, semi structural interviews and focus group interviews. This study was designed as an exploration of the handover process of critically ill patients between nursing staff from the emergency department and the intensive care unit. The study concluded that there was no structured or consistent approach to how handovers actually occurred. Unfortunately, within this particular project the issues relating to written documentation and information sharing were not emphasised.

Forge (2006) explored improving services for children: sharing accident and emergency records in the United Kingdom over a six week period. A comparison was made between the number of attendances of children 0-16 years attending A&E and the number of records reviewed each day by the PLHV. The data was collected through a multi-method approach combining a focus group, one to one interviews and a questionnaire for self-completion. The result revealed that over a six week period 1922 children attended A&E, but that only 1693 or 88.1% per cent

of the records were seen by the PLHV. Whilst the topic was interesting, the study lacked depth in its explanation of the data collection process.

Law et al. (2006) investigated trauma documentation in accident and emergency attendance records. The A&E attendance records of major trauma requiring team care in the resuscitation room from January to June 1999 and July to December 2001 in a Hong Kong hospital were reviewed. Records totalling 128 were included, 46 from 1999 and 82 being from 2001 respectively. The results revealed that the documentation rates on pre-hospital care and injury mechanism was not well recorded. As this study used data from two different periods (methodological heterogeneity) the result may have been affected. It is difficult to identify in the design what steps were taken to explore the source of variation during the different periods of documentation.

Sanders and Cobley (2005) conducted an overview in the United Kingdom of literature identifying non-accidental injury (NAI) in children presenting to A&E departments. The aim of the paper was to review the main issues facing clinicians and nurses in the identification of children at risk of NAI and to discuss policy implications affecting A&E departments. The authors concluded that organisational changes, such as the creation of a shared national database and improved training to A&E staff, are needed to address the under reporting of NAI in young children. The focus on identifying NAI detracts from the importance of written documentation that may help to identify children at risk. Although, it was stated in the overview of the literature that a comprehensive literature search was conducted, it was not possible to judge whether the authors have included all relevant literature and have adequately summarised evidence on the topic.

Taitz et al., (2004) performed a study in an Emergency Department (A&E) in New South Wales, Australia investigating long bone fractures in children under 3 years of age. This study was linked to knowledge of epidemiology and biomechanics of bone injury as the presenting features, mechanism of injury and types of fractures were studied. The data was collected by retrospectively analysing the medical records from the A&E information system. Nine indicators that raised suspicion of abuse, which were developed from the literature, were used. Medical records of the

100 children who presented to the A&E during the period of the study were analysed to see whether any of the suspicious indicators for child abuse were documented. This study highlighted documentation of childhood injury in the emergency department as being inadequate, therefore making any assessment of abuse difficult. The study concluded that doctors in the A&E miss clues of abuse, because they do not look for them in the history and examination, and that they also document their findings poorly. Following the study, a series of education sessions and development of specific referral guidelines were instituted. Consequently, although much of this research into documentation remains valuable, the conclusions on the aspect of record keeping remain at best partial in nature as the research focused on distinguishing injuries due to accidents from those likely to have been caused by child abuse. Original researchers could not be contacted by personal communication[4]; therefore, no additional information was available.

Benger and McCabe (2001) conducted a study in the United Kingdom and investigated burns and scalds in pre-school children attending accident and emergency. This study was to assess how frequently and adequately information relating to the possibility of non-accidental injury (NAI) is documented and considered by doctors, and to determine the effect of introducing a routine reminder into the A&E notes. Records of 100 pre-school children attending an A&E department with a burn or a scald were reviewed against pre-determined standards. The authors concluded that prevailing awareness and documentation of NAI was found to be poor. This study was designed in an attempt to develop a programme of intervention combining education and the use of a reminder checklist to improve documentation in order to reduce the number of child abuse cases that were overlooked. There are some short comings in the paper with reliance of personal opinion. Data to support the argument the authors are making would have been helpful. Personal communication[5] to the original researcher for additional empirical data revealed that no additional information was available, and no further research was being conducted. In the absence of any supporting evidence

[4] E-mails shown in **Appendix 24**
[5] E-mails shown in **Appendix 24**

there is no way of judging the validity or reliability of the conclusions and this seriously undermines the value of the work.

Chan et al. (2000) conducted an international comparison study of childhood injuries in Hong Kong. The records of 7813 children aged 0-15 years of age attending the accident and emergency department from 1996-1997 were analysed. The result revealed that incomplete records comprised 11.3% of all 7813 records studied. The descriptive information demonstrated that only the issue of injuries was explored. However, the authors have acknowledged that the attendance records were chosen as the source of data in this study for pragmatic reasons as they were accessible and did not entail excessive resources. Consequently, only selected items were analysed. Therefore, in relation to history taking, it has been demonstrated that despite the importance of written documentation the focus remained on childhood injuries. Thus consideration regarding the relevance of written documentation was omitted.

Green et al. (1998) assessed the quality of documentation in psychosocial history taking in a paediatric emergency department in South Australia. Case notes of 104 children under the age of 2 years who presented to a paediatric emergency department at least 5 times in one year were reviewed. A prepared list of important elements relating to psychosocial history taking was used to review patient's case notes and then each history was compared to an ideal list. The study concluded that documentation of psychosocial history for these participants was poor, and that the majority of records lacked important information, including basic demographic data.

Christopher et al. (1995) evaluated the extent to which documentation of medical records were completed for dependent children who present for evaluation of an acute injury and to examine factors that favourably or adversely influence chart documentation. Emergency department ledgers of 669 children under the age of nine in the United States of America were utilised. The result revealed that documentation was generally poor. The focus was on recognition and risk management. However, descriptive information demonstrated the disparity of documentation practices and much of the content shows that it could be valuable.

Nevertheless, completeness of documentation was statistically related to mechanism and type of injury, and did not address the factors relevant to written documentation, such as the reasons why documentation was inadequate.

2.7 Methodological issues of the research reviewed

Survey style inquiries predominate and the focus is on a representative sample from a defined population by means of a research instrument such as audits, charts/documents, interviews, and questionnaires. In some cases, it is not possible to establish if the chart/documents really measures factors such as written documentation. To a certain extent they appear to have measured issues professionals believe to be of importance, as the focus of some of the studies reviewed was on statistical accuracy rather than the importance of the data.

2.8 Sampling for the literature review

Across all papers data collection was primarily from documents, therefore the researcher cannot be sure how important the issues of documentation which explores the complexity of human attitudes, and behaviour is to the respondents. Sampling sizes overall were small, although this lends itself to qualitative research approaches (Polit and Hungler, 1999, Crabtree and Miller 1999; Denzin and Lincoln, 2005; Mays and Pope, 2006; Polit and Beck, 2008). See, for example, the studies of Mc Fetridge et al. (2007) and Luderer and Behrens (2008). The data collected were primarily quantitative; as a result, if the estimates are based on a probability level of significance, this would involve a certain degree of error.

According to the work of some authors in the field (Moser and Kalton, 1971; Cartwright, 1983; Crabtree and Miller, 1999; Polit and Beck, 2008) the information obtained in most surveys tends to be relatively superficial as they rarely probe deeply into complexities such as human behaviour and feelings. However, a number of quantitative studies also had small sample sizes; this makes the use of descriptive statistics in particular, somewhat misleading and the demonstration of statistical significance less valuable. Overall, this means that the results cannot be generalised to other populations. The second phase of the literature review discusses issues relating to communication.

2.9 Phase 2 Issues relating to communication

2.9.1 *Communication*

A traditional theory of communication derived from the SMCR (Sender, Message, Code, and Receiver) theory shown in **Figure 2.5** (Shannon and Weaver, 1949) has provided the basis for many books on the process and theory of communication between people (Baker et al. 2002; Tyler et al. 2002; Alder and Rodman, 2003; Higgs, et al. 2005). It refers to communication as conferring through speech, writing or non-verbal means of creating a shared meaning. This view has been taken further by other authors (Fielding, 1995; Lewis, 2006) who suggest that communication is a chameleon of a word that changes the colour of its meaning with a change of speaker or listener and a number of explanations are proposed. For example, the military historian thinks of the army lines of communication, the electronic engineer of telephones and teleprinters, the sociologists of newspapers and broadcasting, in health and social sciences the professional thinks of issues of standards, codes of behaviour and humanity.

Communication is a key skill for all healthcare professionals; it is an essential component of information sharing and revolves around the need for practitioners to be effective communicators (NMC, 2008; HM Government, 2010). This view is supported by both Josebury et al. (1990) and Moss (2008), who emphasise the need for multi-professionals in health and social sciences to communicate effectively across language, cultural and situational barriers. In this project, written communication is relevant as it is the activity of recording and conveying information effectively.

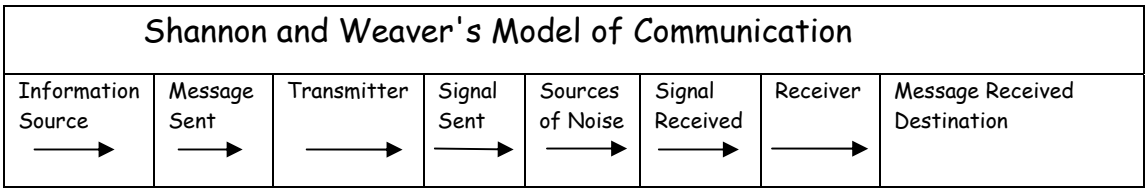


Figure 2.5 Source Shannon and Weaver's (1949) Model of Communication

2.9.2 *Written Communication*

Written communication is one of the two main types of communication and involves any type of interaction, oral/spoken, that makes use of the written word (Higgs, et al. 2005). Therefore it is commonly used in health and social care situations, as it is a major tool utilised by professionals to facilitate quality services for their clients (Fielding, 1995; Clements et al. 2001; Higgs, et al. 2005; Lewis, 2006). Underlying the issue of written communications is a fundamental philosophy of practice (GMC, 2006; NMC, 2008) consequently effective communication is an essential aspect in health care.

Locally when a child presents to A&E and is referred to another professional the method of written communication is their records. Thus the records should take the form of clearly documenting the history or treatment, and/or setting out the rationale for a proposed treatment regime. Such communication needs to be clear, relevant and appropriate in length, content and style (DfES, 2004a; GMC, 2006; NMC, 2008; HM Government, 2010).

In 1995, the Audit Commission's report, Setting the Records Straight, focused on issues relating to the management of health records and the contents of case note folders. The report criticised the quality of paper medical records and reported major problems such as, lack of order and inadequacies of record keeping within the case note folder, low status of records departments, with poor facilities for staff and storage of records, and difficulties in retrieving records for consultations. As a result, the Audit Commission carried out a further study in 1998 which found that there were some improvements in record keeping.

The Kennedy Inquiry (2001) focused on the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1985. Part of the Inquiry included examination of documented evidence from the medical records of over 1,800 children. The Inquiry gave an account of people who cared greatly about human suffering, however, many failed to

communicate with each other, and to work together effectively. The Kennedy report stated:
"Information is the basic building block of any system of standards and quality" (Kennedy Report 2001, p. 394).

Nonetheless, an audit by the Royal College of Physicians (RCP) in 2002 complained about record-keeping practices and standards, as it found similar results to those revealed by the Audit Commission (1995) and the Kennedy report (2001).

A great deal has been written and said about the importance of good communication in health and social sciences (Higgs, et al. 2005). It has been argued that the problems inherent in traditional written case notes is that of deciphering important information, and that the whole area of written communication in clinical records is currently messy and variable (Clements, 1995; Audit Commission, 1995; Fielding, 1995; DH, 1998; Clements, et al. 2001; Scott, 2004; Lewis, 2006; Pullen and Loudon, 2006; Audit Commission, 2009). This issue of inconsistent written communication could partly be due to the increasing size of organisations, therefore as ideas and instructions are transmitted from top down through various levels of management, misunderstanding and distortions are likely to occur as each person makes their own interpretations. This view is supported by both Handy (1993) and Mullins (2010) who argued that it is equally true of information moving upwards from lower ranks to the top, as this can cause serious mistakes to be made and often it is the cause of frustration and low morale.

2.9.3 *Multi-professional communication*

Multi-professional teams rely on clinical records as the main source of information about status and planned care of children (NMC, 2008; HM Government, 2010). As a result multi-professional communication in the health and social sciences is both challenging and rewarding (Fielding, 1995; Burnard, 1997; Baker et al. 2002; Alder and Rodman, 2003; Higgs, et al. 2005). The communication skills of practitioners also have extensive and sometimes severe shortcomings, because physical, social and psychological contexts exert profound influence on the meaning of a message, thereby restricting the health worker's abilities to obtain and

provide information on key issues relating to patient care (Korsch and Negrete, 1972; Maguire, 1984; Mason, 1989; Roter and Hall, 1993).

Reviews and enquiries into the safeguarding of children across the United Kingdom, over the last three decades, often identify the same issues - among them poor communication between professionals and agencies (DH, 1995a; DH, 2002; Laming, 2003; Ofsted, 2007-2008; Balls, 2009). In a multi-professional team such as A&E, the issue of ineffective communication may be caused by perceived differences in status, varied qualified specialities or relationship difficulties with other professionals (Leathard, 1994; Payne, 2000). For that reason those children with the greatest need are a particular issue for A&E, because the support they receive may at times be severely restricted by the nature of the record keeping (Armstrong, 1996; Laming, 2003; 2009;). The most important hazard of poor communication between multi-professionals is a risk to the children, as communication breakdown endangers all children (Laming report, 2003; DH, 2004a; Balls, 2009).

2.9.4 *Record Keeping*

Overall, the principles of effective record keeping advocate that records are clear, succinct, available and complete. For example, clinical notes such as A&E child records need to contain clear relevant information to facilitate communication between care providers and to meet legal and ethical standards (DH and DfES, 2004; GMC, 2006; NMC, 2008; HM Government, 2010).

2.9.5 *Changes in service delivery*

Although the NHS had enjoyed popular support (Klein, 1989), international concern with the rising cost of health care, and increasing awareness that not all treatment was helpful, led to closer examination of professionals' record keeping practices (Dollery, 1971; Alment Report, 1976; Klein, 1982; DHSS, 1983; Maxwell, 1984a; Clements, 1995; Klein, 1997; Audit Commission, 2009). Rivett (2009) draws attention to the way services are delivered and patients treated, from

the time that the NHS was first set up in 1948, including the level of organisational, clinical and financial changes that have occurred[6].

In the 1970s, accountability and cost-effectiveness in the delivery of health care became a major issue; this led to the development of theoretical methods. As a result procedures such as the nursing process, followed by nursing models and Phaneuf's nursing audit (1972) were introduced to assist nurses in determining the quality of their practice. Subsequently these measures were reflected in patients' records and used retrospectively to obtain information for appraising and improving patient care and to monitor standards. The introduction of the planning system in the NHS re-organisation in 1974 highlighted the inadequacy of NHS information, its availability, relevance, quality and timeliness, and in 1982, the report of a confidential enquiry into perioperative deaths suggested that the quality of hospital notes might be poor (Buck, Devlin and Lunn, 1986).

In the case of A&E records, there are some good practices and some practitioners recognise the importance of written communication. However, Fish and Coles (2000) claim that in certain situations practitioners may feel constrained by the uncertainty of what they can do lawfully. They argued that the ever present threat from accountability has been allowed to push the practitioner into such a defensive frame of mind that he or she is constantly in a no win situation. They further suggested that far from being simple, professional practice involves a more complex and less certain real world, in which, daily, the professional is involved in making many complex decisions, relying on a mixture of professional judgement, intuition and common sense.

Although a number of Acts have been developed during the organisational restructure, which was to address the key information technology challenges that face national agencies and local organisations across all care settings, for example, the Data Protection Act (DH, 1998), the information strategy (DH, 1998) and the Freedom of Information Act (ICO, 2000). The flow of information between professionals on the basis of patients' documentation is considered to be poor

[6] NHS history shown in **Appendix 31**

(Benger and McCabe, 2001; Lecher et al. 2001; Laming, 2003; 2009; Taitz et al. 2004; Balls, 2009; Rose and Arbuthnott, 2009). For that reason there is a major drive to computerise medical records across the NHS (see for example DH, 2004; DH, 2006; DH, 2007).

2.9.6 *A&E targets*

In 2000, the government identified a requirement to promote improvements in A&E departments. As a result, the four hour target in A&E was introduced by the Department of Health (DH, 2000), setting an objective that by 2004, the majority of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours. In A&E there is a wide diversity of presenting issues, and most people treated are not children (DCSF, 2009). Some patients may be treated and discharged, others, may require a referral to another professional, and there may also be those cases that need life-saving procedures, for example, in the case of a cardiac arrest. Therefore, due to the diversity of work, when A&E departments have to cope with large numbers of attendances there may not be enough experienced clinical staff on duty who are knowledgeable about working with children in A&E (doctors, nurses) consequently the quality of care given to children is likely to be affected.

2.9.7 *Computerisation of records*

The idea of a national database reflects the importance of ensuring that children do not slip through the net. When Laming (2003) made his recommendation to explore the idea of a national data base for all children (see Chapter 3), he acknowledged the need for a feasibility study and a pilot exercise in establishing such a database. Given that information technology promises changes to the way records are kept, there has been a flurry of research about how best to present children's information in electronic form (see for example: Laming, 2003; DH, 2004; DfES, 2004a; DH, 2007; Dreaper, 2009; Holden and Kelland, 2009). In 2002 the development of information, retrieval and tracking (IRT) systems were initiated to support the accurate tracking and referral of children at risk (CYPU, 2003). It was seen as a key mechanism to help deliver the local preventive strategy. So to reflect a broader remit, from the 1 December 2003 the IRT project became the Information, Sharing and Assessment (ISA) programme which will be discussed later in this chapter.

By complying with the requirements of the ISA programme a window of opportunity has been provided which could be used to combine both computerised and paper-based records, thereby serving new purposes, since the potential of the ISA could be greatly expanded by the computerisation of records (Wheeler, 1969). The National Audit report (2011) claims that central to the aim of improving services was the successful delivery of an electronic patient record. Therefore, it could be argued that improved written records have the potential to bring direct benefits by improving outcomes for children, and thereby improving the performance of the A&E multi-professional team. Thus it seems pointless to simply reproduce the chaotic system of written records into an electronic form. In line with this view, the work of the Royal College of Physicians (RCP) suggests the onus for improving records lies with the individual health professionals (2002). Thus, without improvement in the quality of paper records, the full benefits of computerisation are unlikely to be realised. By improving records, there are potential benefits for the protection of children (**Figure 2.6.).** These improvements are underpinned by government guidance and current legislation (HM Government, 2010) including the Children Act 2004 which provides a legislative basis for better sharing of information.

Improved quality of records	Improved completeness of information
Improved accuracy of information	Better patient information
Improved communication	Greater children involvement in decision making
Accurate performance data	Better research data
Improved outcomes for children	Improved data validity for secondary purposes

Figure 2.6. Potential benefits of improved written A&E child records

2.10 Information/Information Sharing

2.10.1 *Information*

Information is knowledge communicated or received concerning a particular fact or circumstance, and derives from the information theory (Burnard, 1997; Baker et al. 2002; Alder and Rodman, 2003). This is a branch of the communication theory devoted to problems in coding, and provides a formula for measuring information

(Shannon and Weaver, 1949). Historically, it was developed to find fundamental limits on compressing and reliably communicating data. According to the work of Shannon in 'The Mathematical Theory of Communication' (Shannon and Weaver, 1963) information bears a diversity of meanings, from everyday usage to technical settings. Therefore one cannot expect a single concept of information to satisfactorily account for the numerous possible applications of this general field.

Shannon and Weaver's model (1949) supports a tripartite analysis of information in terms of technical problems concerning the quantification of information. Two early examples of the problems raised by analysis of information dealt with by Shannon's theory are semantic problems relating to meaning and truth, and what he called influential problems concerning the impact and effectiveness of information on human behaviour. This, he thought, played an equally important role. Shannon and Weaver's model (1949) embodies the concept of information source and has been widely adapted into the social sciences field (Fielding, 1995; Burnard, 1997; Baker et al. 2002; Alder and Rodman, 2003; Higgs, et al. 2005). Thus information sharing is an important component of information behaviour.

2.10.2 *Information Sharing*

Information sharing is referred to throughout this thesis, it is recognised as an essential activity in all-collaborative work, and helps to bind groups and communities together; therefore it plays a vital part in the work of all professionals in health and social sciences. Thus, the goal is to provide information to others, either proactively or upon request (Payne, 2000; Hutchings et al. 2003). Improving information sharing practice is also a cornerstone of the Government's Every Child Matters strategy to improve outcomes for children (DfES, 2004a). It is clear from the literature that the term information sharing is used in many contexts across a variety of public and private sector, voluntary organisations and services (Hornsby, 1993; Leathard, 1994; Hallett, 1995; Dyer, 1995; Payne, 2000; Hutchings et al. 2003). Information sharing includes providing information, ensuring the communication has been received, and confirming that the message is jointly understood (Shannon and Weaver, 1949; Payne, 2000; Hutchings et al. 2003). However, it is the sharing of information by means of records that is the concern of this thesis.

There has been a wide consensus that information sharing is not only vital in the context of improving services for children, in health and social care, it is also crucial in education, early years child care, youth offending, the police, advisory/supportive services and leisure (DfES, 2004a). Although the emphasis in government policy documents is on integrated working to improve the outcomes for children no one clear definition of information sharing is available (DfES, 2004a; DH and DfES, 2004b; HM Government, 2010). Multiple expectations and definitions exist side by side making it difficult to draw explicit lines in practice. Therefore sharing information can mean different things to different people. It can send quite different meanings and produce diverse interpretations so it is content specific.

Since the emergence of information sharing onto the public service agenda, different types of information sharing have developed and several representations are offered (DfES, 2006; DCFS, 2009; HM Government, 2010). In this instance, the goal of sharing information by means of records is to provide effective communication. Therefore, this enables other community health professionals to fulfil their role in terms of safeguarding and promoting the welfare of children (HM Government 2010). The question in this project is how information can be shared efficiently in order to provide them with the appropriate service.

To imply that the concept of information sharing is a recent and radical goal denies the evidence that historically there has been a cultural barrier to the sharing of information between professionals and agencies. Evidence from past inquiries into deaths of children and recent cases identify striking similarities, and indicate that this is a long-standing issue. Therefore, the goal of minimising the incidence of death and serious harm to children from abuse has not yet been achieved (Laming, 2003; 2009; Balls, 2009). When information is not shared effectively, collaborative group work fails so in order to assist with the effective sharing of information, important links such as the ISA programme (DfES, 2004a) were provided.

2.10.3 *ISA Programme*

The ISA project is an area of development within a programme of work involving local authorities and a range of local partners. It is called Change for Children, and

is led by the Department for Education and Skills (DfES, 2004a). It was seen as a key mechanism to help deliver the local preventive strategy, and stemmed from the Identification Referral and Tracking (IRT) programme, to ensure early identification of children at risk of social exclusion. Subsequently children could be monitored and referred to appropriate services, through improved information sharing between agencies. The work comprised of:

- Clarification of how and when information should be shared by practitioners working with children and young people;
- The development of information systems to assist practitioners with the sharing of information;
- The development of a common assessment framework (**Figure 2.7**);
- Activities to manage change across children's services and to encourage better information sharing.

2.10.4 *Miscommunication*

During the process of information sharing misinterpretations and distortions are likely to occur because of language differences between professionals (such as jargon), assumptions about shared meaning between different cultures and time pressures. The social constructivist theoretical perspective posits that the expression and understanding of emotions through verbal and non-verbal communication are cultural-specific (Russell, 1991). In this context, cultural difference occurs between professions. That is, cultures may communicate emotions differently through tone of voice, choice of words, facial expressions and other physical gestures. Thus, when expressions of emotions are misunderstood, the information conveyed is lost (Samavor and Porter, 1999). For example, an individual providing information may well understand all of its implications, yet fails to realise that the person(s) receiving the message may not. Furthermore, the person(s) receiving the information may not recognise that there are implications; therefore they may be unable to solicit the facts. So although the normal presentation and acceptance phases appear to be functioning well, neither participant knows what the other does not know, as a result there is an undetected breakdown in information sharing. The problem may also be exacerbated when other factors are involved. For example, barriers produced by different social

policies (Garfinkel, 1967; Berger and Luckmann, 1967; Russell, 1991; Ricoeur, 1991; Schutz, 1997; Samavor and Porter, 1999).

2.10.5 *Barriers*

According to other authors (Stainton Rogers, 1989; Hornsby, 1993; Leathard, 1994; Payne, 2000) there may be barriers to effective documentation due to different and conflicting social policy or legislation, interdisciplinary differences and/or different agencies which may be labouring under historical and current jealousies or rivalries. They claim that these barriers occur when individuals involved have different statuses in the organisation at large. Thus an expert in one discipline may not know that an expert in another discipline does not understand. Implications of information that is considered basic in one discipline may not be in another.

The challenges in information sharing in this project are also influenced by inter-organisational, inter-cultural and inter-disciplinary differences which emerge in written communication. Individuals may not always realise that they have specialised knowledge or skills that allow them to understand the implications of information in unique ways, and/or that others may not have the time to develop that understanding. Those receiving the information may not ask about its implications because their understanding is superficial. There are also different core functions of professionals[27] and agencies that may cause conflict or in competition, different values, cultures and practices, lack of clarity of boundaries, and lack of clarity in positions of authority and decision making (Edemariam, 2009; Balls, 2009; Harraher, 2009).

Recent investigation into Serious Case Reviews (LSCB, 2009), implies that the multi-professional team in A&E, and other agencies such as social care, need to overcome some of the long recognised difficulties and barriers in order to provide effective information sharing. This is supported by the work of Rose and Arbuthnott (2009) whose research revealed that there was a failure to keep proper records in a quarter of the cases that were critically cited.

[7] In this thesis I use the term 'professionals' for practitioners who work with children, whether they are employed or volunteers, in the public, private or voluntary sectors.

Following the Victoria Climbié inquiry and the case of Peter Connelly (Laming, 2003; 2009), in order to increase communication the recommendation was to combine education and safeguarding so that policy and practice could be strengthened thereby providing appropriate and consistent governance frameworks. It was considered that this process would promote and support good practice in information sharing as well as ensuring that guidance is embedded in training and education for front line staff and their managers (Laming, 2003; 2009; Edemariam 2009; Balls, 2009; Harraher, 2009; Rose and Arbuthnott, 2009).

Debatably, the issues here are not only professionals' knowledge base, but bureaucratic demands of the system. The Secretary of State for Children, Schools and Families, the Right Honorable Ed Balls[8], on 12 November 2008, took the stance that there was not only failure by individual agencies, but that all agencies failed collectively. He expressed the view that it is important to ensure rigorous scrutiny of the quality of practice and decision making by front line workers and their managers. He also stated that there should be effectiveness of management practice and performance management systems in all relevant agencies (Balls, 2009).

In light of research findings, from practice and experience (Hallett and Birchall, 1992; DH, 1995a; Hallett, 1995; DH, 2000b), and following every serious case review of child abuse, or neglect, there is considerable disappointment that greater progress has not been made to prevent such incidences. Reviews of occurrences across the United Kingdom, over the last three decades, often identify the lack of information sharing between professionals and agencies as a matter of concern (Childhood Matters, 1996; Laming, 2003; DfES, 2004a). The Laming report (2003) states:

> *"There was a consistent failure by doctors and nurses at both hospitals to record information comprehensively, to record shared concerns, and to record and complete the actions that the concerns prompted, worst of all, nobody noticed when things were not being done"* (Health analysis 11 paragraph 11.5)

[8] The Right Honourable Ed Balls Member of Parliament served as the Secretary of State for Children, Schools and Families from 28 June 2007 to 11 May 2010.

Laming's reports (2003; 2009) were clear, they stated that in order to safeguard children effectively, it is essential to make improvements to information sharing within, and between agencies, and that staff must be accountable for the quality of information they provide. It is stressed that shared responsibility for promoting the wellbeing of children and safeguarding them from significant harm depends upon effective information sharing, collaboration and understanding between agencies and professionals (Working Together to Safeguard Children, HM Government, 2006; Balls, 2009). Hence a further attempt was made by the Government to reduce the barriers in information sharing by introducing the Contact Point (Chapter 3) database (DCSF, 2009), but the information it contained was very limited, therefore significant information may not always have been recognised or utilised (Rose and Arbuthnott, 2009).

2.10.6 *A&E Child records*

These records (see Chapter 5) involve every child attending A&E and the multi-professional team members in A&E who assess these children. For where there may be a cause for concern, the multi-professional team are implicated since they make decisions about the safeguarding of children. Within the context of this thesis, drawing from sociological theorists (Berger and Luckmann, 1967; Garfinkel, 1967; Ricoeur, 1991; Schutz, 1997), when information is shared by means of A&E records acquiring, sharing, and processing information are critical activities for decision making. Their perspectives suggest that we examine information; not as objective missives, but rather by recognising that information is inextricably intertwined with the social settings in which it is encountered. Thus in such situations, in order for it to have value, it requires a subjective and social interpretation of those involved.

It is stressed that shared responsibility for promoting the wellbeing of children and safeguarding them from significant harm depends upon effective information sharing, collaboration and understanding between agencies and professionals (Laming, 2003; 2009; HM Government 2010). Therefore, in this study, information is inextricably linked to the A&E department and the perceptions, views and understanding of the varied staff who share the information. Thus subjective and social interpretation in the decision making process requires collaborative working.

2.11 Collaborative/ Inter-professional working

Collaboration, teamwork, inter-professional working, integrated care, and interagency working are all terms which are currently cited in government documents in the United Kingdom (DH, 2000; DH and DfES, 2004b; DCSF, 2007; HM Government, 2010). These terms are frequently employed to highlight the need for families and providers of services to work together to meet the needs of children (Leathard, 1994; Payne, 2000).

The terminology 'collaborative' implies that a range of activities can be combined (Hornsby, 1993; Leathard, 1994; Loxley, 1997; Payne, 2000), nonetheless, because the activities are socially constructed, they are used by different people to mean different things. The idea of collaborative working and interlinking professionals' skills was borrowed from teamwork in management and derives from the human relations school of management theory. It was developed in the 1930s and first flowered in the 1950s (Payne, 2000). Given the prominence of collaborative practice, it is not surprising that it has been extensively researched. Contribution has come from a large number of disciplinary perspectives including sociology, business policy, economics, geography, public policy, politics and management. Various authors (Glendinning, 1986; Sloper et al. 1999; DH, 2004; Townsley, Abbott and Watson, 2004; Brandon et al., 2006) expressed the view that collaborative working is likely to focus on enabling and encouraging professionals to work together. They suggested that it may facilitate practitioners in adopting common processes. For example, the delivery of frontline services that are coordinated and built around the needs of children and young people. This is supported by Jong and Jackson (2001) who suggest that in health care the term should be used to denote multidisciplinary management, care collaboration, service collaboration or linkage.

Service collaboration has been a key part of the vision for children's services since the launch of the quality protects programme in the late 1990's (Middleton et al. 2003; Calder and Hackett, 2003; Cleaver et al. 2004; Brandon et al. 2006). Together with the aims of the Children Act 1989 (DH, 1989), and the research findings from practice and experience (Hallett and Birchall, 1992; DH, 1995; Hallett, 1995; DH, 2000b), this programme sought to increase interagency

collaboration in children's services. Due to its associations with other plans, increased attention has been paid by policy makers and practitioners in developing effective systems to reflect and assess the needs of children. These systems included the WTSC document (DH et al. 1991), which was designed to provide a framework to enable co-ordinated response from professionals, and facilitate interagency/inter-professional child protection practice.

In this project, collaborative practice refers to working across organisational boundaries. Therefore, collaborative working is not only influenced by the philosophy of care, but also by organisational determinants, such as structural domain, on the framework of practice that are demonstrated at macro, meso and micro levels (cross reference Chapters 4 and 5).

In the last decade, there has been a shift from national health services being organised around the needs of professionals to those of children's requirements. Therefore appropriate understandings can only be achieved by working across professional boundaries (Loxley, 1997; DfES, 2004a; HM Government, 2010). According to Pietroni (1994) this model of multi-professional working was transferred into the NHS and became the structural means of exchanging information, resources and services. The belief is that effective relationships with all groups are likely to improve how we share information and the responsiveness with which we deal with the safeguarding needs of children (NPS, 2003; DH, 2004; DH, 2006; DfES, 2006; DCSF, 2009; HM Government, 2010).

According to Hennemann et al. (1995) and Hudson (1999b) collaboration itself is a complex phenomenon. Various models have been explored, and different philosophies of team working can present difficulties for multi-professional work. Despite the lack of conceptual clarity surrounding the idea of collaboration, attention within both academic and policy literature has largely focused on the difficulties of putting it into practice (Lupton and Khan, 1998; Freeman et al. 2000). They argued that conflicts are inherent in inter-professional and interagency collaboration due to social differences in the division of labour, and knowledge of ways of working priorities. They refer to the cause as being deep rooted differences which have developed historically between professionals in the health and welfare

services. Whilst the work of Loxley (1997) argues in favour of collaboration, she suggests that collaboration is not simply co-operation between team members, but she goes on to explain that collaboration means working across boundaries and that this challenges the safe reductionist view.

2.11.1 *Inter-professional working*

Authors who contributed to the views on inter-professional working, (Likert, 1961; Mc Grath, 1991; Hornsby, 1993; Hallett, 1995; Dyer, 1995; Adair, 1996; Hutchings et al. 2003) argued that it offers co-ordination. They believed that by bringing skills together it encourages the development of collaboration; therefore it could achieve a greater strength in the provision of accessible, high quality, flexible, and user-friendly service to the population. Thus, the sharing of information would enable resources to be better managed thereby assuming a better focus for the benefit of the service user (children). This has been advocated in government papers (DH, 2004; DfES, 2004a; HM Government, 2010) as a solution to improve services for children. Therefore, the Integrated Children's (ICS) System (DH, 2000) that supports inter-agency collaboration was introduced and incorporated into the WTSC (DH et al. 1999) document. This was to be used for all assessments undertaken under inter-agency guidance, and was underpinned by the domains and dimensions set out in the Framework for the Assessment for the children in need and their families[9] (shown in **Figure 2.7** below).

More recent documents to promote the principles of increasing inter-agency collaboration in children services are shown in **Appendix 33**. It was acknowledged that there was potential value in the Contact Point system (DfES, 2008), as it provided a quick and reliable means of determining the professionals who were working with the same child. However, following the formation of a new coalition government on 11 May 2010, the Department for Education announced that Contact Point was to be decommissioned (Chapter 3).

It is recognised that A&E is a most important area for inter-professional working between services such as social care, paediatrics, general practice and charitable

[9] See Chapter 3.

organisations (DH, 1995a; Children Act (Scotland) 1995; Northern Ireland Order, 1995; Laming, 2003; 2009; HM Government, 2010). Therefore, the professional diversity required, emphasises the need for inter-agency and multi-disciplinary working and co-operation (DfES, 2004a). Consequently, having people who can work together is the key to successful collaborative working (DfES, 2004a), as failure to share concerns about a child's welfare could later lead to major criticisms of the practitioner if a child was found to have suffered significant harm (Parton, 2006). Since not every member of staff in A&E has the same knowledge and experience, their insecurity in their own professional knowledge could impact on inter-professional working Dombeck (1997) states:

"Articulating disciplinary and professional identity is important before inter-professional relationship can be successful. It is difficult to form collaborative ties when one is unsure of one's professional identity" (p.5).

Therefore, in this situation, the PLHV's experience and knowledge contributes and provides the confidence to share information with others. However, through lack of knowledge in their own professional role some A&E staff may feel threatened by staff from other professions, so, how they work together as a multi-professional team may be affected. Indicators for positive inter-professional team working appear to be communication within the team, personal qualities and commitment of staff, and the opportunity to develop creative working methods (Molyneux, 2001).

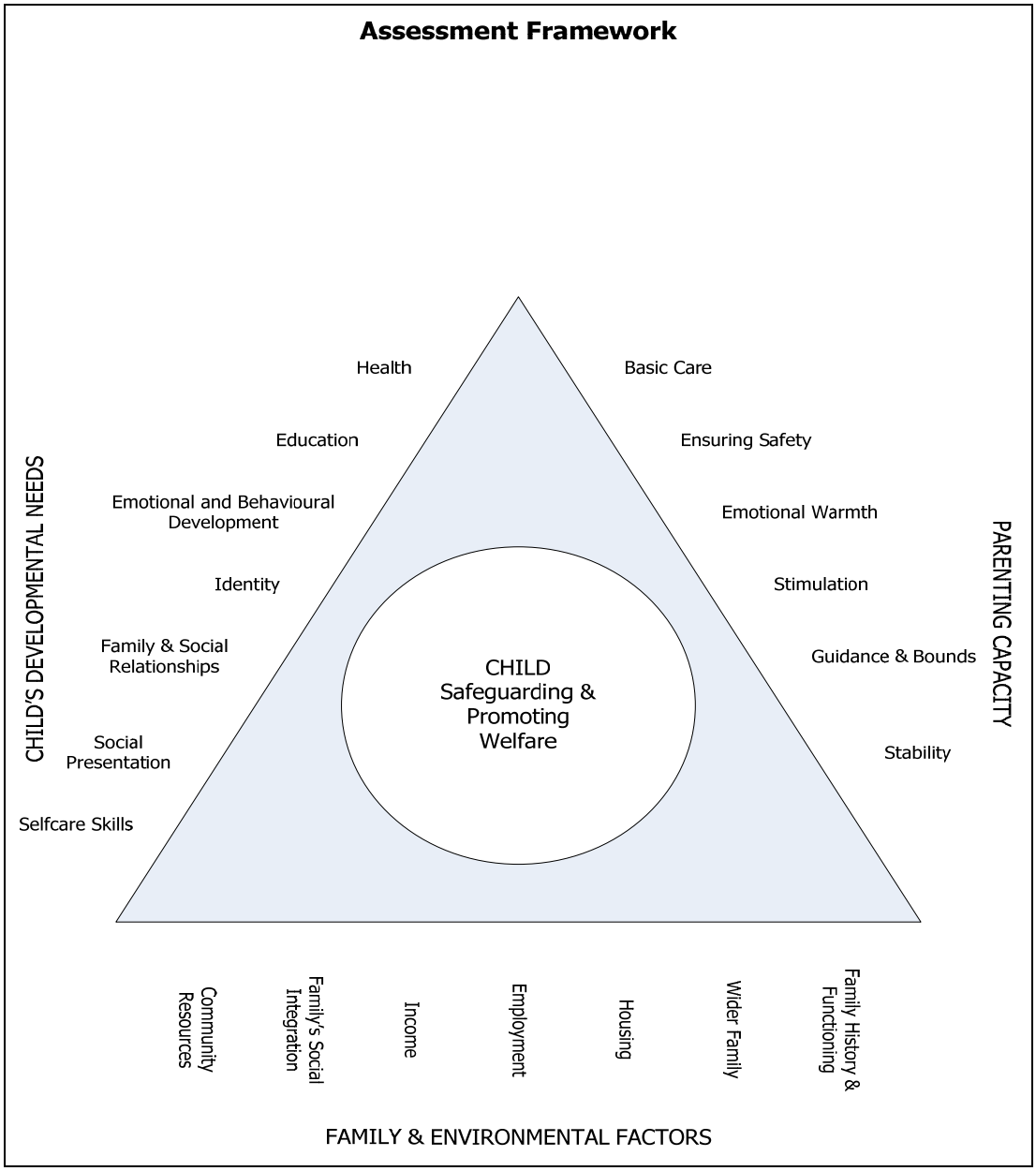


Figure 2.7 .Adapted from Working Together to Safeguard Children: a guide to inter-agency working - (DH et al. 1999 p.104).

2.11.2 *Partnership working*

Effective partnership between agencies and professionals who have different roles and expertise is an important factor in safeguarding children (DH, 2004; DfES, 2004a; DH and DfES, 2004b). Therefore, statutory guidance (DH, 2004; DfES, 2004a; DH and DfES, 2004b) set out how organisations and individuals should work together. Thus, the changes in children's legislation were prompted by the development of the WTSC documents (DHSS, 1988; DH et al. 1991; DH et al. 1999b; HM Government, 2006; HM Government, 2010).

Although the implementation of the Children Act (DH, 1989) determined that children should be protected from abuse, in the WTSC (DH et al. 1991) there was a shift from protecting them from abuse to safeguarding and promoting their welfare. This contrast is made clear when a comparison is made between the two documents (DH, 1989; DH et al. 1991). For, although the 1991 version had been written to be consistent with the 1989 Children Act (DH, 1989) in light of Messages from Research (DH, 1995a), the direction and rationale of the WTSC document was transformed. As a result the focus in 1991 was the protection of children from abuse, whereas the 1999 version (DH et al. 1999b), clarified and underlined the importance of inter-agency work. Therefore, different styles of integrated working influenced and changed the directions and patterns of everyone who worked within children services. Subsequently, there was general acknowledgement amongst practitioners that inter-agency working and adherence to procedures promoted good practice (Hewitt and Leach, 1993; Hallett, 1995; Jack, 1997; Stevenson, 1998).

The Government's response to the Victoria Climbié inquiry report and the first joint Chief Inspectors' report (DH, et al. 2003) identified key features of an effective system to safeguard children. These were informed by the Green Paper Every Child Matters (DfES, 2003b) and the Children Act 2004, and set the context for the revised guidance of the WTSC (HM Government, 2006). This document reflected major developments in legislation and contained statutory and non-statutory practice guidance. The key messages included the need for shared responsibility and effective inter-agency working with supportive services. This included the use of A&E child documentation for good record keeping as an important element of integrated care. As a result, it was proposed that in practice the focus should be shifted from targeting children at risk of significant harm to a more positive partnership between children, families professionals and services, with facilities co-ordinated and developed around the needs of the children (Laming, 2003; 2009; and DfES, 2004a; HM Government, 2010).

Directly relevant to effective partnership working by means of child records in A&E is an analogy by Marriotti (1996). He suggests that effective organisations

need effective relationships with suppliers, distributors and consumers. In the case of A&E child records (illustrated below in **Figure 2.8**) translates into:-

- *Suppliers*, children, parents/carers, agencies, and professionals who refer the children to emergency services;
- *Distributors*, services providers who are part of the package of services for children in the community;
- *Consumers*, children, families, and society.

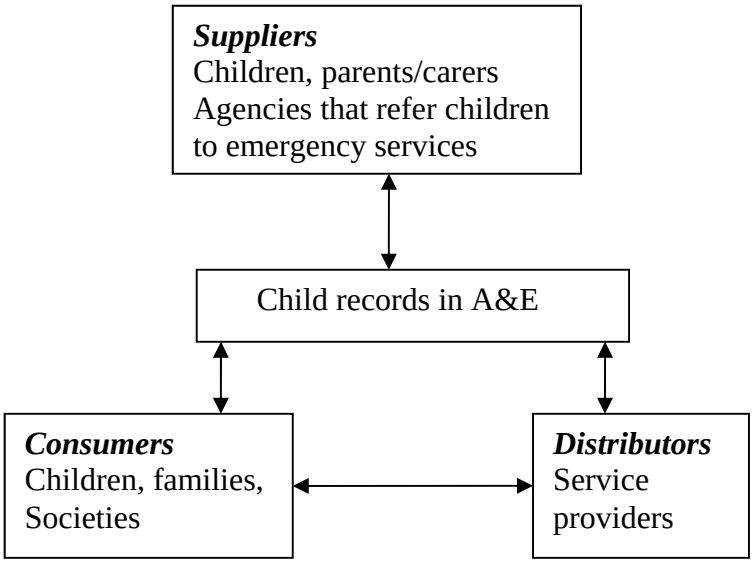


Figure 2.8 Effective Partnership Working

The difficulty here is that a tension remains between the creation of A&E records to provide support for vulnerable children presenting to emergency services, and the needs of parents to fulfill their parental role. On one hand, it is one thing to state that agencies should offer services to safeguard and promote the welfare of children; however, it is quite another issue, to encourage a reluctant parent to accept the support. When the method of information sharing is by documentation, there are several issues in the decision making process that have to be considered, for not only does it pose real dilemmas for practitioners as they need to listen to parents, there are also issues of informed consent, ethical issues, and the differences between privacy and confidentiality. These are issues faced daily by the multi-professional team in A&E and need to be adequately addressed given that the parents' position is reinforced by the principles of the Children Act 1989 (DH,

1989), and the underlying belief that parents have the right to bring up their children as they wish as long as the children are not at risk.

A typical A&E department is staffed by a multi-professional health care team (Healthcare Commission, 1998; RCPCH, 2003), therefore, for any child presenting to emergency services they would assess the child's needs and make the necessary referrals to other agencies. According to Laming (2003; 2009), A&E is in the frontline of care, and he indicated that the WTSC (HM Government, 2006), is helpful in setting out the expectation that staff in A&E should be able to recognise abuse and be familiar with local procedures. This document clearly emphasises the duty placed on employers to ensure competency in their workforce, and it does feature good record keeping as an essential part of professional accountability and good practice (Appleton, 2006). However, what has not been addressed either in this or the latest version of the WTSC documents (HM Government, 2010) are issues relating to information sharing associated with the role of a PLHV in A&E. In a collaborative situation, such as in this case, the PLHV works as part of the A&E multi-professional team. Whilst the document quite rightly stresses the need to ensure that effective, high quality information is provided and shared, it fails to identify that current measures to audit practice are seriously limited.

2.11.3 *The role of the PLHV*

The role of the PLHV is not standard in A&E departments in the United Kingdom. Although this role is not explored to any extent in this thesis, it is relevant to this project as it facilitates information exchange, thereby ensuring continuity of care. Factors influencing the role of the PLHV are stated below: The Royal College of Paediatrics and Child Health multidisciplinary Working Party report - Accident and Emergency Services for children (1999) states:

> *"The employment of a liaison health visitor aids communication at the interface between A&E, in-patient services and primary care, and facilitates notification to family health visitors of the attendance of all children under five years, and to the school nursing service for 5-16 year old. The latter aids appropriate targeting of health promotion activities and action on injury as highlighted by the recent Green and White papers, as well as any child protection issues"* Recommendation 10.4, page 19, paragraph 5).

The Laming report (2003) states:

"Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm" (Recommendation 90, paragraph, 12. 57).

The report of the Intercollegiate Committee for Services for Children in Emergency Departments, The Royal College of Paediatrics and Child Health (January 2007) states:

"The sharing of information is enhanced by a liaison health visitor. All emergency departments should follow the recommendations of the Laming enquiry" (p.23).

2.12 Findings of literature review

The literature review has indicated that the approaches used in documentation and information sharing have a multiplicity of meanings as they are used in many contexts across a variety of organisations and services. Thus, it is indicated that because communication is based on, cultural, social, psychological and technical systems, there is an inter-relationship that inter-plays between the varying factors.

The review identified that the number of child abuse cases reported to the child protection agencies was lower than would have been expected (see for example Taitz et al. 2004; Gilbert et al. 2009). It highlights documentation of childhood injury in the emergency department as being inadequate, therefore making any assessment for abuse difficult. Attention is drawn to the fact that health professionals are the first point of contact for identifying non-accidental injuries, however, many cases remain undetected (Christopher et al. 1995; Taitz et al. 2004; Saunders and Cobley, 2005; Laming, 2003; 2009; Gilbert et al. 2009). The review reveals that doctors in A&E overlook clues of abuse, because they do not look for them in the history and examination and that they also document their findings poorly. An indication is given that poor reporting continues when practitioners do not know how to interpret evidence that is unclear (Gilbert et al. 2009). The review also suggest that there is significant overlap by health professionals working within the hospital setting and professionals from other agencies such as the police and social services, in identifying cases of child abuse. As a result, concerns remain which revolve around actions taken by professionals, since these could have a major impact on the detection of children at risk of abuse (Laming, 2003; 2009; Gilbert et al. 2009; Balls, 2009).

Evidence highlighted that A&E professionals were not eliminating the possibilities of child abuse in their diagnostic work. Although clinical investigations can offer a profile of the likely pattern of injury, it was identified that there is an urgent need for multi-professional communication between health professionals, social services, the police, child protection teams, and the need for A&E staff to assist in the evidence building process (Fung et al. 2002). An indication is given that training is an issue, since professionals need to be aware that even in the absence of any previous recorded child protection concerns, a thorough clinical assessment should incorporate a comprehensive history.

The importance of contemporaneous written record keeping is reiterated, and it is intimated that A&E staff members may be relying on subjective opinion or issues of plausibility when making decisions on clinical or social risk factors. The findings suggest that there is correlation between quality written documentation and information sharing (DH, 1995a; DH, 2002; Laming, 2003; 2009; HM Government, 2006; Balls, 2009). The following key themes were identified which address the issues surrounding information sharing by means of written documentation.

2.13 Key themes

- Communication – although multi-faceted and complex, communication is a key skill required for all healthcare professionals; it is an essential component of information sharing and revolves around the need for practitioners to be effective communicators;
- Documentation – it has been identified that record keeping in A&E is inadequate, and that it not only affects the decision making process, but it also impacts on practice, thus standards need to be improved;
- Training – an indication is given that training is an issue, since professionals need to be aware that even in the absence of any previous recorded child protection concerns, a thorough clinical assessment should incorporate a comprehensive history;
- Process – evidence shows that poor reporting continues when practitioners do not know how to interpret evidence and that doctors in A&E overlook

clues of abuse, because they do not look for them in the history and examination and that they also document their findings poorly.

2.14 Conclusion

This chapter provides a synthesis of the current state of evidence of the topic of safeguarding children by means of documentation and information sharing. It identifies and organises key ideas relevant to the conduct of the investigations from which the contribution to knowledge will be made. Literature reviewed for this study offers evidence of the national and international situation, provides an overview of the existing evidence of the problem being addressed and demonstrates the need for this study. What emerges are complex issues relating to the everyday life problems in communication, and gaps in information sharing. There are fundamental problems of meaning and interpretations added to the influential problems associated with the impact of recurring child protection scandals.

Whilst the area of safeguarding children is developing with greater focus on better information sharing reflected in major policy and practice, the importance of the human element has not been addressed. The review indicates that there remains a significant gap in literature exploring the importance of the social construct people place on documentation and the perceived associated value of conveying that information to others. Although some multi-professionals understand the implication of their actions with regards to the sharing of information and are able to engage with the complexities of meanings that are often social, emotional, economic, cultural, political and technical it is a very difficult challenge. Whilst research in the United Kingdom and elsewhere has studied a wide range of variables that may influence the use of child records for the safeguard of children, government and multi-agency/multi-professionals continue to be confused as to how to respond to the crisis concerning documentation and effective communication.

The following chapter therefore analyses government legislations, policy documents, the unresolved issues in child protection, and presents a critical evaluation of the child protection process as a case study.

Chapter 3 The Child Protection Process

Phase 1 Analysis of government policy documents

Introduction

In the previous chapter, the following key points have emerged: factors influencing documentation and information sharing are highly complex; standards of documentation are insufficient; and child abuse cases are under reported. The promotion of safeguarding children continues to be a government priority in many countries, due to the political sensitivities raised when a child dies and there is an established failure of child protection services to identify risk.

This chapter presents an analysis of the current United Kingdom (UK) child protection process. It is divided into two parts. In the first, there will be an overview of the child protection process in the UK (England, Scotland, Wales and Northern Ireland). It begins by defining the term, safeguarding. This is followed by discussions on relevant government documents. The second part will focus on the issues arising out of a recent child protection case which particularly relates to the failure to learn aspects of child protection relevant to this thesis - the case of Peter Connelly (Baby Peter) who died in 2007.

The series of public enquiries (Blom-Cooper, 1985; DH, 1988b; Kennedy, 2001; Bichard, 2004; Laming, 2003; 2009; LSCB, 2009) since the 1970's have resulted in legislation and policies[10]. The policy Every Child Matters (DfES, 2003b) highlights the fact that safeguarding and promoting the welfare of children is a vital task and prompted the current safeguarding policy the WTSC document, (HM Government, 2006), later updated, (HM Government, 2010).

3.1 Safeguarding process

The term safeguarding has been expanded over recent years. The Shorter Oxford English Dictionary (2007) defines safeguard in terms of: protection, safety, security, custody, safekeeping, guarantee of safety given by a person in authority. In this instance, the term safeguarding refers to keeping children safe from harm by means of sharing information (DfES, 2004a; HM Government, 2010).

[10] See **Appendix 32**

Therefore, safeguarding children depends on effective partnership between agencies and professionals who have different roles and expertise (DHSS 1988; DH et al. 1991; DH et al. 1999b). Responsibility lies primarily with parents and carers, but all professionals working with children have safeguarding responsibilities. Every Child Matters, (DH, 2004a) details how organisations and individuals should work together to safeguard and promote the welfare of children. This statutory guidance highlights and indicates that the safety of children should be at the centre of the community's priorities. This is based on the principle that children are our future and safeguarding children is everybody's responsibility (Cutts, 2006). Cutts (2006) suggests that it is almost absurd to think that living in a civilized and highly sophisticated society, such as ours, that we should even have to make a statement about the safeguarding of children. She further suggests that in reality not all members of our civilized society regard children in a positive way (Cutts, 2006).

Even though safeguarding and promoting the welfare of children is supported by government legislation, such as the Children Act 1989 (1989), these documents simply propose that measures should be in place to improve their safety. Thus, there is no clarification of the term safeguarding in law or government guidance. The second Joint Chief Inspectors' report on arrangements for safeguarding children (DH, 2000a), merely defines safeguarding, as keeping children safe from harm.

The report by Sir William Utting (DH et al., 1997), People Like Us, which is often referred to as the Safeguarding Review, underlines the importance of the concept of safeguarding. Whilst his report discusses policies and practices in relation to children living in public care, the notion of safeguarding is also seen as a minimum requirement for ensuring every child's physical and emotional health, education, and sound social development. Consequently, safeguarding and promoting the welfare of children is defined and supported by government legislation in terms of protecting children from maltreatment, preventing impairment of children's health or development, and ensuring that children were growing up in circumstances consistent with the provision of safe and effective care (DH, 2000).

Child protection

Child protection is defined as being the part of the safeguarding process, whereby it is necessary to intervene if there is a reasonable belief that a child is at risk of significant harm[11] (HM Government, 2006; 2010). Child protection in the UK was the responsibility of the Department for Education and Skills (DfES). However, since 2007, when this department ceased to exist, the Department for Children, Schools and Families (DCSF) took up overall responsibility. According to the 'Children's Plan: Building Brighter Futures', (DCSF, 2007) the aim of the DCSF was to enable the United Kingdom to be the best place in the world for children and young people to grow up.

In 2010, following a General Election and a change of government, the responsibility was transferred to the Department for Education (DfE). The DfE is responsible for issues affecting people in England up to the age of 19 years; including child protection and education. It issues both statutory guidance to local authorities[12] (which must be adhered to) and non-statutory guidance (which the DfE suggests local authorities follow). Local authorities use the guidance to produce their own procedures, which should be adhered to by practitioners and professionals who come into contact with children and their families, in their particular local authority area.

In the United Kingdom, under the Children Act 1989 (DH, 1989), paramount consideration is given to the protection of children and their welfare, although the implications in terms of prevention were not always identifiable in policy and practice. The emphasis, for example, in the Children Act report of 1993 (DH, 1994) had been on providing services for children who have suffered harm or are likely to

[11] The Working Together to Safeguard Children document (HM Government 2006, p.35) states that: "*some children are in need because they are suffering, or likely to suffer significant harm. The Children Act (DH, 1989) introduced the concept of significant harm as a threshold that justifies compulsory intervention in family life in the best interests of children, and given Local Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer significant harm*".

[12] The Working Together to Safeguard Children document (HM Government 2006, p.27) states that: *"Local Authorities are responsible for social services and education. Section 63 of the Children Act (DH, 2004) defines Children's Services in England as: a county council in England; a metropolitan district council; a non-metropolitan district council for an area where there is a county council; a London borough council and the Common Council of the City of London."*

suffer harm in the future. However, following publication of the document Child Protection Messages from Research (DH, 1995a) it was proposed that there should be a preferred option to protect the majority of children who may be at risk of abuse and neglect.

Nevertheless, it was highlighted that there was no clear definition of abuse, the Scottish Executive (2002) states that:

"There is no single agreed definition of what child abuse and neglect is and definitions have changed over time. Abuse can be physical, sexual or emotional. It may be acute or a long-term pattern of neglect. Often children are abused in more than one way" (Chapter 1. Paragraph, 1.3.).

3.2 Child protection process

Legislation to protect animals was introduced before children were afforded the same privilege (Polnay, 2001). Although child protection legislation has been in force since the 1880s enabling prosecution of people accused of child cruelty; it has taken a series of investigations into high profile child abuse cases and deaths to establish the child protection system in existence today (Ferguson, 1992). It is likely that further change will be triggered by future cases.

It is generally recognised that there is guaranteed coverage of a child neglect case by media when the circumstances are particularly shocking. On average, about 80 children die of abuse or neglect in England and Wales every year, and there have been more than 70 public inquiries since the Children Act 1948 (Batty, 2003). The first post war public inquiry was a response to the death of Dennis O'Neill, and to public concern for the position of orphaned or deserted children and the subsequent breakup of the poor law functions of the local authorities (Curtis Committee Report, 1946). The report stated that Dennis died as a result of the treatment he received from his foster parents. The demise of Maria Colwell, a 7-year-old beaten to death by her stepfather in Brighton (DHSS, 1974), triggered another national debate over the care of children which led to the establishment of the modern child protection system. Further changes were prompted partly by the inquiry into the death of 4-year-old Jasmine Beckford (Blom-Cooper, 1985). The neglect and abuse, which led to her death, occurred whilst she was in the statutory care of the Local Authority. A more recent case is the death of 8-year-old Victoria

Climbié in 2000, who died as a result of months of ill-treatment at the hands of two individuals who were supposed to be caring for her (Laming, 2003). During the last few months of her life, she had come to the attention of doctors in two hospitals and social workers in two local authorities, but she remained unprotected. The most recent case is that of Peter Connelly, who died in 2007, whilst he was on the Child Protection Register.

Following the death of Victoria Climbié, the first Laming (2003) report was instrumental in influencing the legislative framework for today's child protection system. In England and Wales the legislative framework is found in the Children Act 1989 (DH, 1989), in Northern Ireland, the Children Northern Ireland Order 1995 (DH, 1995) and in Scotland in the Children (Scotland) Act 1995 (DH, 1995). These acts have since been amended by subsequent legislation. For example, since 2002, the United Kingdom has put in place a substantial body of legislation, such as the Children Act 2004 and the revised Working Together to Safeguard Children policy (HM Government, 2010) which has served further to enshrine the well-being of children in legislation. The current recent legislation encompasses the principles of the United Nations' Convention on the rights of the child (UNRC, 1991) and creates an effective national framework to support positive outcomes for children. Nevertheless, although discussion of the child protection system for the rest of the United Kingdom could be advantageous, due to the limitations of this thesis only the child protection system which is organised and structured in England is discussed and analysed.

3.3 The Children Act 1989

In England, the most important legislations are the Children Acts 1989 and 2004. They provide the legal framework which establishes the responsibilities for everyone working with children and young people. Primarily, the Children Act 1989 was the key legislation for children in England. The overriding principle of the Children Act (DH, 1989) is that the prime concern should be the welfare of children (Aldgate and Tunstill, 1995; Farmer and Owen, 1995; Thoburn et al., 1995; Audit Commission, 1994; Parton, 1997). The Act defines childhood as the period up to a young person's 18th birthday. Until that age, all children in the United Kingdom are entitled to the protection of the state to ensure their safety and

well-being. The Children Act 1989, which encompasses children in England, is founded on the requirement that the welfare of the child must be the court's paramount consideration in any decision relating to his or her upbringing. This Act (DH, 1989) has been informed by child abuse inquiries, research, and in the 1980's by other official reports such as the Short Report (Social Services Committee, 1984), and the Review of Child Care Law (DHSS, 1985) which sought to update childcare legislation. Whilst the essential principles at the core of the Children Act 1989 provide the legal framework for child protection in relation to individual cases, it attempts to make both the content and the operation of the law fairer to all (Aldgate and Tunstill, 1995; Farmer and Owen, 1995; Thoburn et al., 1995; Parton, 1997).

Under the Children Act 1989, a court must give particular attention to the ascertainable wishes and feelings of the child concerned, bearing in mind his or her age and understanding; his or her needs and how these can be met; any relevant personal background; any harm suffered or risk of harm; and the likely effect of a change in circumstances.

It has been suggested by Parton and Otway (1995), that a crucial element in debates surrounding the Children Act 1989 (DH, 1989) should include the criteria which should be used for making decisions. They argued that because of this, the assessment of high risk had become central and was framed in terms of significant harm (Parton and Parton, 1989a; 1989b; Parton, 1991). However, the Children Act 1989 does not provide a definition of significant harm. Nevertheless the criterion for state intervention (for example, care proceedings, supervision orders and emergency protection orders) is that the child concerned could be suffering, or is likely to suffer significant harm. This suggests that for the first time, the basis for state intervention should incorporate a prediction of what may occur in the future (Parton and Otway, 1995).

The Children Act 1989 states that intervention should be evidence led and should amount to the minimum required to protect the child. This approach, also known as Neo-Liberalism, perceives the state to be capable of violating individual rights if it is not limited in its function (Burden, 1998). An illustration of this is found in the

government guidance accompanying the publication of the Children Act 1989. At the very beginning of the Children Act 1989 it is stated that:

"Potent powers, if misdirected, may themselves cause harm to a child by enabling the state to intervene in his or his (sic) family's life when it should not"(DH, 1989, p.6).

Paxman and Jordan (1991) argue that the Children Act 1989, introduced by the Thatcher government, was not consistent with other social legislation. They implied that within the political landscape of that time, politicians did not want to be perceived as either not having children's interests at heart or being anti-family; therefore, the Act was introduced largely unchallenged. Nonetheless, cumulative recommendations from reports, inspections and findings of Child Protection Messages from Research (1995a) informed the government's thinking regarding ways in which the systems could be altered and modernised.

3.4 A Joint Chief Inspectors' Report

Three months prior to the Laming report (2003), the first Joint Chief Inspectors' (JCI) Report on Arrangements to Safeguard Children was published (DH, 2002a). This report was significant, because it identified the key features of an effective system to safeguard children. It was jointly produced by the Inspector of Social Services, Director for Health Improvement, Commission for Health Improvement, Her Majesty's Chief Inspector of Constabulary, Her Majesty's Chief Inspector of the Crown Prosecution Service, Her Majesty's Chief Inspector of the Magistrates' Courts Service, Her Majesty's Chief Inspector of Schools, Her Majesty's Chief Inspector of Prisons and Her Majesty's Chief Inspector of Probation. This emphasised the common responsibilities for safeguarding across government.

The JCI report (DH, 2002a) task was to develop joint arrangements to inspect the services of others. This report illustrated that the safeguarding of children should no longer be the sole responsibility of social services. It also demonstrated that safeguarding children should be accommodated under the authority of numerous government departments and should be the central responsibility of Government (Parton, 2006).

The JCI report (DH, 2002a) argued that there were few formal agreements as to how and when information should be shared. They commented on the development and functioning of services in relation to potential dangerous persons and their relationship with the established arrangement for protecting children (DH, 2002a). Whilst there were established arrangements in health and social care for sharing information, there was no consistency or formal links with the police and probation services with which to address common concerns. Although Multi-Agency Public Protection Panels (MAPPS) were in place in all areas, there was no detailed national guidance (Parton, 2006). Consequently, there were no formal links between MAPPS and the Child Protection Committees (ACPC). The responsible authority for each area, comprising of: the police, prison and probation service, provided the lead for arrangements. Therefore, these concerns were delegated to the Multi Agency Public Protection Arrangements (MAPPA). The process is determined by the Criminal Justice Act (NPS, 2003) (section 325-327), it is designed to bring together key agencies (police, prison and probation services) to co-ordinate and manage those individuals returning to or already in the community, who present a risk of serious harm to the public in general and to children and vulnerable adults in particular.

The overarching recommendation of the JCI (DH, 2002a) was to ensure that the safeguarding of children be consistently reflected in national and local service planning. The issue of safeguarding children could no longer be one that affected only a wide range of professionals and agencies, it required government involvement. In an attempt to reduce the complexities of the systems set in place, a further practice guidance called What to do if you're worried a Child is Being Abused was published (DH et al., 2003).

Although, the title of the document suggests that its focus was child abuse, it clearly reflected concerns about the wellbeing of children, which was seen as central. This document focused on various processes in individual cases and also on the nature of significance and concerns, which were highlighted both in the Working Together to Safeguard Children document (HM Government, 2006) and the Assessment Framework (DH, 2000a).

3.5 Laming report

As a result the death of Victoria Climbié, the first independent inquiry held by Lord Laming was initiated. He was appointed to chair an independent statutory inquiry into the circumstances leading up to and surrounding her death and to make recommendations as to how such an event, as far as possible, could be avoided in the future. His inquiry identified information sharing as a major shortcoming, which had resulted in a failure to protect Victoria Climbié and resulted in changes to child protection legislative framework and policy documents in England[13]. The report contains 108 recommendations for fundamental changes to the way social care, healthcare and police child protection services are organised and managed at national and local level, in order to establish a clear line of accountability in the provision of services for vulnerable children and the support of families. One recommendation directly relates to information sharing:

The Government should issue guidance on the Data Protection Act 1998, the Human Rights Act 1998, and common law rules on confidentiality. The Government should issue guidance as and when these impact on the sharing of information between professional groups in circumstances where there are concerns about the welfare of children and families (Laming, 2003, Recommendation 16: *paragraph 17.116).*

Whilst, the report was generally welcomed; the recommendations by Lord Laming echo those of previous reports, back to the first formal child death inquiry, known as the Curtis Committee Report (1946).

Batty (2003) argues, that in spite of the fact that there have been at least 70 public inquiries into tragic failures in the British child protection system, 67 of which concern cases in England, the Laming report (2003) repeated many of the recommendations from earlier reports. He argues that anybody reading the media coverage of the Climbié inquiry, who knew little of the subject, could be forgiven for thinking that what had happened to Victoria was an isolated incident, or that the inquiry was making recommendations to ensure such a tragedy would never

[13] See **Appendix 32**

happen again. Batty (2003) contends that when Lord Laming began his 15-month inquiry into the brutal murder of Victoria Climbié, he pledged that her death would mark an enduring turning point in ensuring the proper protection of children in this country, and suggests that this long-awaited report into one of Britain's most high profile child abuse scandals appeared to be yet another missed opportunity (Batty, 2003). Circumstances clearly proved this to be the case (LSCB, 2009).

There are particular issues associated with improvement of communications amongst staff and services involved in safeguarding children which are crucial to effective child protection. Firstly, diverse professionals share the information A&E child records contain. This professional diversity, particularly across agencies, has caused obstacles in child protection and emphasises the need for inter-agency and multi-disciplinary professionals working and co-operating together in practice as well as in policy terms (DfES, 2004a; HM Government, 2006). The Laming report (2003) argues that those children with the most pressing needs present particular difficulties for A&E departments. It notes that there is an association between inadequate information sharing and some child deaths which have occurred following attendances at A&E, minor injuries units or walk in centres. Lord Laming's report (2003) clearly states that in order to safeguard children effectively, it is essential to make improvements to information sharing within and between agencies. Staff must be accountable for the quality of information they provide. Nevertheless, the key problems do not lie solely in the professionals' ability to collect the necessary information, but also in their capability to interpret it accurately and to communicate coherent decision-making as a necessity (LSCB, 2009).

The Laming (2003) report stresses the importance of information sharing and shared responsibilities in hospital environments and with community services and that procedures should be checked.

"Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. The Department of Health must ensure that those working in such liaison roles receive child protection training. Compliance with child protection policies and procedures must be subject to regular audit by primary care trusts." (Laming, 2003, paragraph, 12.54).

However, the report is inadequate in offering guidance as to how multi-professional teams in A&E departments should be supported in their quest to effectively share information. It is possible that the multi-professional team may benefit from help which enables them to stand back from the case and re-evaluate the information available. The Laming report (2003) did recommend child protection training.

Although the report led to the mandatory status of child protection training for all staff, the issue of auditing was not addressed from the Laming Commission. Problems are identified regarding the issue of free exchange of information. In his report, Lord Laming (2003) states:

"I was told that the free exchange of information about children and families about whom there are concerns is inhibited by the legislation on data protection and human rights. It appears that, unless a child is deemed to be in need of protection, information cannot be shared between agencies without staff running the risk of contravening this legislation. This has two consequences: either it deters information sharing, or it artificially increases concerns in order that they can be expressed as the need for protection. This is a matter that the Government must address. It is not a matter that can be tackled satisfactorily at local level"(paragraph 1.46)

The sharing of information by means of A&E child records is not necessarily as clear-cut as may first appear. For example, Lord Laming's (2003) comments in his report infer that practitioners are not only held responsible for the quality of the information they provide, but they are also inhibited by legislation. There is tension here between reasonable judgement, and professional and confident sharing of information**.** Nevertheless, decision-making remains an issue for the multi-professional teams in A&E as diverse staff are sharing the information contained in the records.

One of the key proposals following the death of Victoria Climbié was the creation of a national database to track all children under 16. Laming (2003) argued, that there are doubts about the exchange of information between services and inadequate client information systems. He referred to the context of a highly mobile society whereby over ninety million people passed through the port of entry

each year. He inferred that in the absence of a national database, children are unnecessarily exposed and vulnerable. Laming (2003) states that:

"The Government should actively explore the benefit to children of setting up and operating a national children's database on all children under the age of 16" (Recommendation 17).

In response to the above recommendation, the British Government (DCSF, 2008) created Contact Point. This was an online database which contained basic information about every child and young person in England from birth to their 18th birthday (DCSF, 2009). It was created under the Children Act 2004 to enable the children's workforce (social and health professionals together with formal and informal educators) in every local authority area in England to fulfil duties prescribed for their employing organisation. Those duties are: co-operating to improve the well-being of children in the local authority area (Section 10); and to co-operate to safeguard and promote the welfare of all children (Section 11). Whereas Section 12 of the Children Act 2004 enabled the Secretary of State for the DCSF to publish regulations, which require local authorities in England to establish and operate a database, or databases, that contain information about children and young people in relation to the duties set out in sections 10 and 11 of the Act (DH, 2004).

Nevertheless the Laming (2003) report came to have a much wider relevance for all children, given that its formal response to the Victoria Climbié inquiry, alongside the Joint Chief Inspectors' Report on Arrangements to Safeguard Children (DH, 2002a), was influential in improving the child protection process. Child Protection in England: A Progress Report was ordered by government and called for an overhaul of the process of children's social work (Laming, 2009).

The Contact Point database has been subject to criticism by many (Munro, 2005; Penna, 2005; Dowty, 2007; Peckover et al., 2008; Žižek, 2008), who suggest that the drive to put child protection on-line could lead to an array of emerging systems, which, at best, duplicate each other. They took the stance, that a national drive was required in order to clarify the legal situation. Batty (2003) draws attention to a

child protection investigation which was launched by the county council, together with the police, following an incident when a mother took her son to an A&E department requiring treatment for a wrist injury. The doctors there had access to the at-risk register, which incorrectly contained the child's name. They then made a referral to social services although there were no outstanding concerns. This episode and the various explanations for it have exposed a flawed system.

When Lord Laming (2003) made his recommendation to explore the idea of a national database for all children, his report suggested that he was aware that it may be fraught with difficulties. Whether a child's name appearing on a database is a matter of choice is the assumption here. This amounts to a reversal of one of the basic views in the Children Act 1989 (DH, 1989), which presumes that families know best as how to support their children (Munro, 2005; Peckover et al., 2008; Žižek, 2008).

On June 1st, 2010 the Department for Education (DfE, 2010) (the renamed Department for Children, Schools and Families) issued the following statement - The communiqué stated:

"We [the new Conservative/Liberal Democrat Coalition Government] are scrapping Contact Point. *We will develop better ways of keeping children safe. The investment made won't be wasted because we can use the technical expertise we've acquired to protect those children most in need. But the idea of a single national IT database for all children has gone for good"*.

On 6th August 2010 the database was switched off.

On December 27th, 2012 in a press release, in the Guardian newspaper the Government proposed that all children taken to hospital accident and emergency departments are to be logged on to a national database from 2015 (Malik, 2012), as a result concerns regarding the database continues to be debated.

3.6 The Green Paper Every Child Matters

This advisory Green Paper (DfES, 2003b) was published in September 2003. It stated that effective services to all children depend on improved information and collaborative working at an early stage in order to prevent problems. Every Child Matters (DfES, 2003b) makes it clear, that the government had planned to remove

the legal, technical, cultural and organisational barriers of information sharing, in order to provide, for the first time, effective communication between everybody who has a responsibility for children (CYPU, 2003).

Every Child Matters (DFES, 2003b) was an early intervention to improve information sharing. Given that Lord Laming's (2003) recommendations influenced reforms and made it clear that child protection policies could not be separated from policies aiming to improve children's lives as a whole; this was planned to be achieved through establishing a common assessment framework[14] (DH et al., 2000b).

In order to enhance the information sharing process there was a plan for integration of professionals, co-location of services and the introduction of a lead professional. The clear message was that not only would child protection be seen as embedded in the new systems, but also it would be reflected in the criteria for inspections and practice standards for agencies with responsibilities for children. There would be shared responsibility spanning agencies for protecting children through new statutory duties (Payne, 2004; Munro, 2004b, 2004c; Parton, 2006).

Ideally, information systems would be based on national data standards capable of interacting with other data sets. Therefore, concerns from a range of professionals would be obtained enabling the exchange of information between local authorities, and partner agencies, in order that core information follows the child between different services. As a result the proposals that were central to Every Child Matters (DfES, 2003b) for improving the collection and sharing of information were built on the Identification, Referral and Tracking (DfES, 2004) project in order to ensure that all children were correctly included. The long-term aim was to incorporate information between services to ensure that professionals share their concerns at an early stage.

It was also suggested, that a strong case existed for giving practitioners the ability to flag early warnings onto the system when they had a concern about a child.

[14] See **Figure 2.7**

However, although concern is not defined in the Every Child Matters (DfES, 2003b) document, the Government has made it clear, that where a child is at risk of significant harm, information sharing should be allowed to go far beyond the situation in which it is currently approved. So in the case of using child records, concerns would emanate from the A&E multi-professional team assessing the child. Consequently, the decision to place a flag of concern on a child's record, which could be picked up by another agency, would be the responsibility of practitioners.

Parton (2006) argues that flagging in itself may not meet the thresholds of intervention. Therefore, in the case of A&E child records, it may mean that although the practice of flagging would enable and encourage professionals to improve the process of information sharing, children, who are already at risk of harm, could possibly be overlooked due to the fact that A&E is such a challenging clinical area, where patients with major and minor traumas, illnesses and injuries are treated and the workload is unpredictable. Ultimately, the changes proposed in the Every Child Matters document (DFES, 2003b) and by Laming (2003), regarding greater accountability, responsibility and governance of practice, did consider how change could be effected locally. Nonetheless, decision making in the context of safeguarding the wellbeing of children in the Green Paper (DfES, 2003b) has been built into the Children Act 2004.

3.7 The Children Act 2004

The Children Act 2004 amends the 1989 Act. It places a particular duty on local authorities to make arrangements whereby key agencies can co-operate to improve the wellbeing of children and young people. Although the duty upon agencies to cooperate with each other under section 27 of the Children Act 1989 (DH, 1989), is still retained, under the Children Act 2004, the wording of duty to cooperate is more robust. For the emphasis has shifted from agencies having to respond if approached by another agency, to having a duty to actively arrange and promote co-operation.

Whilst information sharing for the purpose of safeguarding children is crucial under section 31 of the 1989 Act, under the Children Act 2004 this is no longer

essential. As a result, clarification on how to overcome some of the long recognised difficulties and barriers that may be impacting on effective information sharing is limited. Differing agency core functions of professionals and agencies may cause conflict in methods of recording of child records due to differing service priorities, values, cultures and practices, lack of clarity of boundaries, lack of clarity in positions of budgetary authority and decision making. There are also historical and current rivalries between agencies, diverse and conflicting social policy or legislation under which agencies may be labouring (Stainton Rogers, 1989).

Within the Children Act 2004, increasing emphasis is placed on integrated working. It is stated that the Government's goal is to engage all services in the drive towards better safeguarding, largely through prevention. There are some areas of uncertainty. When professionals share the information that A&E child records contain it should be beneficial to have a coherent procedure, but there could be differing perspectives based on interpretations of the needs of the child.

The ISA programme initiative (Chapter 2) provides guidance to professionals as to how they should communicate with other agencies about the needs of the child, understanding what information should be shared with whom and under what circumstances, together with pointing out the dangers of not doing so (DfES, 2006). A clear and serious attempt is also made to address the tension associated with poor communication between agencies and the safeguarding of children, such as children who present to an A&E department, but live outside of the local area.

3.7.1 *Civil Liberties*

The Children Act 2004 is often presented as a solution to some of the technical problems associated with information-sharing and inter-agency working concerning the welfare of children. According to Penna (2005) the Children Act 2004 contains two important sections that have significant implications for civil liberties. In particular, the development of information, retrieval and tracking systems (IRT) which raises questions concerning rapid growth in the use of instruments of surveillance. According to the document Every Child Matters (DH,

2004a), the benefits which the Government intended the system to provide for children and young people in England, were to enable all agencies to work together more effectively. Nevertheless, whilst Section 10(2) of the Act includes the contribution made by the child to society, and specifies five areas that are subject to surveillance in the interests of the child's welfare, Section 12 of the Children Act facilitates the establishment of electronic data-bases to track the progress of all children in England and Wales.

Penna (2005) argues that a very large-scale system of data recording carried out by the state on its citizens has civil rights implications. She states that a system set up with the aim of improving the welfare of all children, the names and key personal details of all 11 million children in England would be recorded and professionals from a wide variety of disciplines would have access. Such information sharing using child records, if all the records were to be shared electronically, would have significant implications on civil liberties, because the majority of children attending A&E are not at risk of suffering harm. Research carried out on behalf of the Office of the Information Commissioner found that children and young people had concerns about the erosion of their privacy (Hilton and Mills, 2006). This may discourage them from seeking help and information from official agencies, as an example health. A similar view is held by Research undertaken for the Joseph Rowntree Reform Trust, which concluded that the IRT system cannot be made compliant under the European Convention on Human Rights without being substantially redesigned (Anderson et al., 2009).

Safeguarding also encompasses the rights and needs of the child. When civil rights are considered, there is an expectation of entitlement to something, but when needs are reviewed there is a sense of deficiency (Hill and Tisdall, 1997). Adults tend to be more comfortable talking about children's needs rather than their rights, but are likely to see children's needs as being different to those of adults. Within the context of rights and needs, children are constrained by social divisions spanning the societies in which they reside. Therefore, children may be construed as being in need or entitled because of their social context, for example, class, economic circumstances, gender, or ethnic background (Jones et al., 2008).

According to Laming (2003) and DfES (2003b) it is recognised that most decisions regarding information sharing require professional judgment. For that reason, in the case of child records, a great deal depends on the professional's judgement, because there are no clear boundaries as to what information should be shared on children considered to be at risk. As a result, within this framework, when information is shared by means of A&E records, children may be differentiated and discriminated against. Penna (2005) and Mansuri (2008) suggest that through the adoption of a new legal category of concern, the criterion relating to information sharing would give significant power to the multi-professional staff in A&E who come into contact with children. Thus, confusion between different agencies about what information should be shared on children at risk exists. This could partly be due to differing views on the human rights legislation, data protection and patient confidentiality. Whilst there are no immediate answers to the tensions and dilemmas raised in respect of the rights of the child within this thesis, the consideration of the rights of the child is placed in the context of information sharing governed by statutory and specific policies.

3.8 Every Child Matters: Change for Children

This is a legislative document, introduced by the government to effect change commencing in 2004. It initiates comprehensive changes to the way children's services are structured in England (DfES, 2004a). This document sets out a framework for improving services for all children and their families to protect them, promote their wellbeing and support them in developing their full potential. It proposes to deliver five outcomes, these being; to be healthy, staying safe, enjoying gaining achievements, making a positive contribution, and economic wellbeing.

The rhetoric may be very interesting, yet, fundamental questions and issues arise. These relate to how these five outcomes are to be achieved when information is shared. For whilst Every Child Matters: Change for Children (DfES, 2004a) was inspired to a considerable extent, by the Victoria Climbié inquiry (Laming, 2003) this was not the only driver. The JCI report (DH, 2002a) also influenced change (discussed previously). The publication of the Green Paper Every Child Matters

(DfES, 2003b), the passing of the Children Act 2004, and the publication of Every Child Matters: Change for Children (DfES, 2004a) marked an important turning point in opinion about children's services in England. According to Teachernet (2009) the Every Child Matters document (DfES, 2003b) also prompted public debate about services for children, young people and families.

Schools were also involved in the consultation that led to the publication of the government document Every Child Matters: Change for Children (DfES, 2004a). Now all schools have the task of ensuring that the aims and objectives enshrined in in this document are henceforth met in every aspect of school management, leadership and planning. The use of Every Child Matters: Change for Children in the Criminal Justice System (DfES, 2004b) was also significant. This document gives an account of responsibility and action plans for various agencies to focus on preventing children from offending. The document, which consists of seven pages, provides a short summary of aims and action for this particular group of children and omits as much as it contains. There is no clear government guidance on information sharing, thus if every child really matters, this piece of legislation needs clarification (Jones et al., 2008). Nevertheless, the Working Together to Safeguard Children document (HM Government, 2010), states that information sharing and inter-agency working is the key in providing holistic care.

3.9 Working Together to Safeguard Children

The Working Together to Safeguard Children document (HM Government, 2010) is a revised guidance of the Working Together to Safeguard Children (HM Government, 2006). This document was updated to reflect changes to the policy and legislative landscape on Serious Case Reviews and addresses 17 of Lord Laming's (2009) recommendations. The document (HM Government, 2010) sets out the parts that are particularly relevant to different roles and is addressed to senior staff, operational managers, practitioners and front line managers who have particular responsibilities for safeguarding and promoting the welfare of children.

Improving information sharing practice is a cornerstone of the Government's strategy to improve outcomes for all children and this is exemplified in recent

policy and guidance including Every Child Matters (DfES, 2004a). According to the Information Sharing Guidance for practitioners and managers (HM Government, 2008) professional judgement must be used to decide what information is appropriate to share or not, unless there is a statutory duty or a court order in place enabling them to share. Where there is a clear risk of significant harm to a child, or serious harm to an adult, any decision to override a refusal to provide consent should only take place when it is in the public interest to do so. Therefore, it is important to maintain an appropriate balance between protecting the confidentiality of individuals and allowing appropriate information sharing between professionals. However, in the revised document (HM Government, 2010) the issue of consent remains ambiguous, because there is no clear guidance about satisfying the public interest.

The key responsibilities of health professionals and organisations in safeguarding and promoting the welfare of children are examined in both the last and newer versions of the Working Together documents (HM Government, 2006; 2010). These are linked to Standard 5 of the NSF (DH and DfES, 2004b). For the first time in many years, the Children's NSF (DH and DfES, 2004b) provides an explicit commitment from government to improve the lives and health of children and young people in England. This is a joint policy initiative between health and social care. The Children's NSF is a 10-year programme intended to stimulate long-term and sustained improvement to children's health. It sets standards for health and social services for children, young people and pregnant women. The NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, continuing through to adulthood. It does not restrict itself solely to the NHS area of services, but focuses on all areas of service provision which have an impact on a child's or young person's life, health and well-being.

Following the case of Baby P (Peter Connelly) concerns were raised that, more than six years on, not all of Lord Laming's (2003) recommendations had been implemented. Therefore, the Secretary of State for Children, Schools and Families commissioned Lord Laming to provide an urgent report detailing the progress being made across the country, also, to implement effective arrangements for

safeguarding children. Lord Laming's main task was to evaluate the good practice that has been developed since the publication of the Statutory Inquiry following the death of Victoria Climbié (Laming, (2003).

3.10 The Protection of Children in England: A Progress Report

The report of this review was published in 2009 (Laming, 2009). It includes 58 additional recommendations, many of which were directed at Government, but there were also recommendations directed at children's services organisations and key agencies.

The report (Laming, 2009) highlights gaps in the child protection system and suggests that there is a lack of communication between relevant agencies. Attention was also drawn to the fact that the reforms recommended following the death of Victoria Climbié, had still not been implemented. According to Laming (2009), whilst the improvements in the services for children and families were welcomed in general, it is clear that the need to protect children and young people from significant harm and neglect was extremely challenging. He emphasised the need to change working practices in the arrangements to protect children from harm. He argued that it is essential that action should be taken immediately so that, as far as humanly possible, children at risk can be adequately protected. He expressed concerns about inadequate data systems, social work training and workforce stresses together with failures to implement the new legislation and communication guidance across agencies. He was concerned about the profile of child protection work within the police. He drew attention to the lack of effective support and challenge to agencies, expressed doubts about the effectiveness of the inspection of services, inconsistent social care thresholds and a perceived crisis in the health visiting service. In both his reports (Laming, 2003; 2009), he argued that all staff within A&E should be trained to recognise signs of abuse and neglect; also no child should be discharged whilst concerns for their safety or well-being were suspected. He further suggested, that in order to protect the child, there should be somebody available, at all times, with the updated knowledge required to take appropriate action should a child be subject to a child protection plan.

However, Laming (2009) acknowledges and recognises in his report the enormity and complexity of the task facing child protection/ safeguarding services. Laming (2009) claimed that, despite the fact that progress had been made in inter-agency working to safeguard children, significant problems remain in the day-day reality of sharing information, together with working across organisational boundaries and cultures. Ultimately, the safety of a child depends on staff having the time, knowledge and skill to understand the child or young person and their family circumstances. This all too often depends on the commitment of practitioners. Therefore, for safeguarding to be fully effective in protecting children such as Peter Connelly, it needs to be a part of the social fabric, not an institutional response to referrals, or a technical exercise in risk management. Included in the findings (Laming, 2009) were the implementation of the Every Child Matters (DH, 2004a) agenda encompassing agencies and the development of new legislation and statutory guidance (HM, Government, 2006) to assist professionals.

3.11 Munro Review of Child Protection

On 10 June, 2010 the Secretary of State for Education appointed Professor Munro to review the child protection system, in order to enable it to be free from unnecessary bureaucracy and regulation. The aim was to understand why previous reforms have not resulted in the expected level of improvements. The focus was on strengthening the social work profession, thus making it possible for them to be in the best position to make well-informed judgements. This should be based on up-to-date evidence with the best interests of children in mind.

Therefore, the review draws on the extensive informative analysis and evidence which was submitted from both Lord Laming's (2009) and the Social Work Task Force (DCSF, 2009) reviews. In Professor Munro's report, the approach for the review and the child protection issues that needed exploring were explained. The initial report to the Government was submitted in September 2010 and published on 1 October 2010.

Her final report on child protection in England was published in May 2011 and made practical recommendations. This report (Munro, 2011) considered the child's journey through the protection system – commencing with the need to receive help,

it also shows how the system could be improved and reflects on the fact that the effectiveness of help as well as the experiences of children, young people and families are central to recommendations for reform. The report also highlights the importance of having a stronger focus on understanding the underlying issues that influence professionals behaving in the way they did and what prevent them from being able to help and protect children appropriately.

However taking into consideration the serious cases of failure which have consistently indicated poor quality in recording and sharing of pertinent information between agencies, the report does not reflect issues regarding documentation and information sharing in great depth. On the other hand, the review does highlight that there are some deficiencies within current recording practices and expresses the view that the Integrated Children's System (DCSF, 2008) does not go far enough in the creation of chronologies and the child's history. The summary of the above government documents which influenced the current child protection system in England are shown in **Appendix 32.**

3.12 Phase 2 Critical evaluation - The case of Peter Connelly (2006-2007)

The case of Peter Connelly makes a significant contribution to the child protection process in England. As shocking as it was, the case of Baby Peter does not hold a unique place in child abuse enquiries. This case is significant as an indictment of the current child protection arrangements in the United Kingdom particularly with regard to hospital records and inter-agency communication.

According to the LSCB (2009) report, baby Peter had already been placed on the Child Protection Register when he died at the hands of his mother, her abusive boyfriend and their lodger. He had suffered more than 50 injuries despite receiving 60 visits from social workers, doctors and police over an eight-month period (LSCB, 2009).

Quotes extracted from the LSCB report indicate that there were issues in terms of his care, assessment of his needs, differing styles/power relationships and the link to A&E child records. Consequently, the first issue discussed, is caring for Peter.

3.13 Caring for Peter

Caring is embedded in relationships with obligations such as parenthood, in which people feel responsible for children and are required to attend to their needs (DH, 1989). The attention given to Peter by his mother involved a feeling of being responsible for his care (DH, 1989); therefore, this parental sense of responsibility was fundamental to how Peter's mother executed her role and reflected on assumptions of her sense of duty.

The LSCB's (2009) document includes a chronology of events in Peter's life, and illustrates that the abuse of Peter began from his earliest days. The LSCB report states that:

"Prior to the birth of Peter, it was known that his mother struggled to cope with small children and that after one birth she suffered from post-natal depression" (LSCB, 2009, paragraph, 3.4).

"Peter was regarded as a routine case, with injuries expected as a matter of course, and the case was given the standard and well tried approach to a family in need of support. Clearly nobody knew what the psycho-social problems/needs possibly were, reflected in Peter's injuries and the neglect of at least one other child" (LSCB, 2009, paragraph, 4.1.10).

Parental responsibility is recognised in the Children Act 1989 and emphasises requirements and duties that parents have towards their children. Relationships with children are not voluntary; therefore they can never be seen as being quite the same as those between adults (Hoggett, 2004). As a result, feelings of obligation have consequences for both the lives of children and their parents. The concept of parental responsibility recognises that in relationships between parents and children, parents may be connected but not attached. In other words, there may be times when a parent has difficulties in bonding with their child emotionally; therefore, the uniqueness of individual parents should be recognised if the appropriate strategies are to be used for conducting an effective, supportive programme. Evidence from the serious case review states that information gathered about this family may not have been comprehensive (LSCB, 2009), therefore, insufficient attention was given to the needs of the parent, which in turn influenced parenting capacity and outcomes for baby Peter (Farmer and Owen, 1995).

The LSCB (2009) report implies that service providers, such as the health visiting service, social care and schools, shared erroneous assumptions about the relationship between Peter and his mother. Notions regarding closeness and love were taken for granted and may have hindered these service providers. As a result, this may have had an influence on how service providers responded to this family's situation and in the forms of help that were proposed and offered (Twigg and Atkin, 2002). There is also an issue regarding relationship between the perceived expert and the service user, a relationship that is defined by structures put in place to try to manage risk (DfES, 2006). In this case, perhaps the service providers needed the understanding and definition of the family's problems and how this is influenced by relationship. By working in this way, the situation could have been linked to the assessment process, thereby enabling service providers to make an accurate assessment together with effective intervention.

3.14 Assessment process

Assessment is not an end in itself, it is a process to provide a holistic understanding of the child's needs (Ward and Rose, 2002; Middleton et al., 2003; Calder and Hackett, 2003; Cleaver et al., 2004; Brandon et al., 2006). The development of the framework for assessing children in need and their families (**Figure 2.7**), was taken forward as part of the Quality Protects: Transforming Children's Services Programme (DH, 2000). Thus, a key principle of the Assessment Framework is that children's needs and their families' circumstances, requires inter-agency collaboration to undertake a full understanding of the situation and to ensure an effective service response (summary of the analysis stages are shown below in **Figure 3.1**).

- a child's needs must be based on knowledge of the expectations of this child's development;
- parenting capacity should be drawn on knowledge on what is reasonable to expect on parental care given to a similar child;
- family and environmental factors should be drawn from knowledge on what the impact these would have on both parental capacity and directly on a child's development.

Figure 3.1 Analysis stages (DH, 2000)

The LSCB report states that:

"On 5th March, the school nurse phoned the social worker to say that she had observed Ms A that day shouting loudly and slapping the cheek of one of Peter's siblings outside the school. The sibling was seen alone and confirmed the assault. Ms A had already agreed to attend a parenting programme and the social worker proposed no further action" (LSCB, 2009, paragraph, 3.38).

Subsequently, An Integrated Care Pathway approach (ICP) was required to meet the needs of Peter's family, together with a holistic assessment which recognises that care needs vary (Middleton et al., 2003). According to the Common Assessment Framework (CAF), the development of this pathway (DfES, 2006) should follow the Early Intervention Journey (**Figure 3.2** below). Therefore, an assessment should have been carried out, not only to assist any other children involved, but also in relation to adult services, whether for the parent or in planning transitions for the other children.

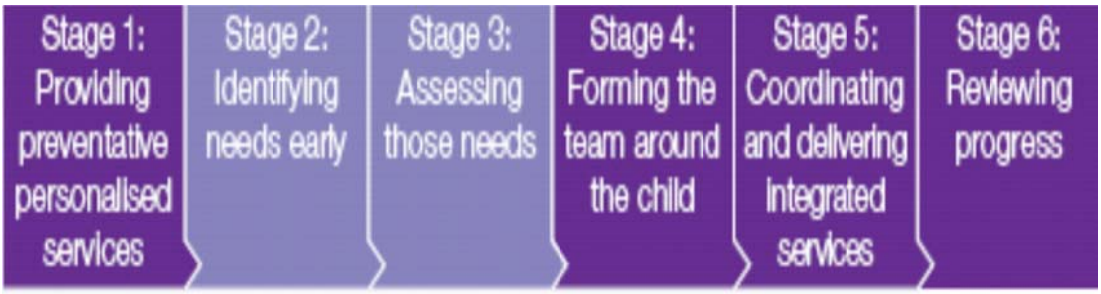


Figure 3.2 Early Intervention Journey Source: CAF, DfES 2006, page 27

Although the CAF (DfES, 2006) correctly places the child at the centre; this document does not address the issue of risks adequately. Assessing risks is not purely about assessing the situation of harm from parents/carers to the child; it is a compilation of important events, both acute and long standing, that interrupts changes or damages the child's physical and psychological development which can cause harm (HM Government, 2006).

It has been suggested that the assessment process has, at times, separated the professional from the individual, because it has been steeped in bureaucracy (Middleton et al., 2003). As a result of this, the regulations and procedures become the dominant discourse in the professional's narrative, rather than the needs of the child. For that reason, much of the complexity of interwoven emotional relationships could be reduced and made more straight forward. Perhaps, the reason

that mistakes are still being made could be that the assessment framework is not explicit or does not relate accurately to how the issue of risk affects children. For example, in the case of Peter and his family, there was no visiting matrix. For that reason, assumptions were made, and individuals did not appear to know who was visiting at any one time or when visits occurred. Hence, issues concerning his welfare may have been simplified, and sanitised accounts of reality would have been given. For example, The LSCB report states that:

"Ms A's attendance at the Mellow Parenting programme. This health-led programme offered an intensive day long experience of social learning and support for parents with relationship difficulties with their children. The social workers who commissioned the programme saw Mellow Parenting as an important current arrangement in protecting Peter and the other child on the register, and also for the longer term in helping Ms A to be a more thoughtful parent. The social workers and the programme providers had different expectations of each because they were not clarified" (LSCB, 2009, paragraph, 4.2.1).

The impression given is that in providing for the needs of the family, neither the social workers nor the providers of the Mellow Parenting programme negotiated or clarified what was needed or expected from this programme. This occurred despite the fact that professionals felt that this was a family in need. Sadly, it reflects conventional habits of practice, with the added issue that a clear pathway was missing. Clarifying expectations and assessing the needs of the family involves time, imagination and effort. The issues here have obvious relevance in relation to documentation, information sharing, knowledge and experience. Thus, it is only by these extensions that safeguarding children like Peter becomes possible. Therefore, this case highlights the importance for different professionals to work together appropriately.

3.15 Different professional approaches

It is clear from the list of personnel involved (**Table 3.1** below) with the care of Peter, that not only did they represent a range of tasks, but different roles and positions within the arena of child protection. The agencies involved were so diverse, that these personnel exhibit considerable differences in status and power and they all varied greatly in the levels of discretion exercised. The use of discretion also varied with the degree to which they drew on their professional models of practice, guidelines and policies.

3.15.1 *Guidelines and policies*

Legislative requirements dominate agency policy making in respect of the safeguarding of children and the number of statutory obligations has been exemplified. The way in which safeguarding of children policies are constructed varies between differing service providers. Therefore, the degree to which professionals apply their particular knowledge and experience varies with practice, which ultimately, in this case, appeared to have detrimentally affected Peter's care. Guidelines and regulations governing the work of front line practitioners are sometimes put together in practice guides, flow charts, policies, and procedures.

Health Visitor	Providing health visiting care
Social worker	Social care service
General Practitioner	Providing general practice care
Paediatrician	Providing paediatric care
Children & Young People's Service (CYPS)	Conducting enquiries and subsequently implementing agreed child protection plan
Primary Care Trust (PCT)	Providing A&E, outpatient, day patient and in patient care and diagnostics including pathology and radiology
Two Acute hospital NHS Trusts	Providing ante-natal post-natal, A&E, outpatient, day patient and inpatient care
A regional hospital	Providing, on behalf of, the PCT paediatric medical services including the designated and named doctors for child protection and the paediatric A& E and inpatient services
Police Service	Working with and alongside the CYPS to jointly investigate reported injuries to Peter
The Epic Trust and Family Welfare Association (FWA)	Offering specific tenancy and family support using an Individual Support Plan
Two local schools	Offering support
Legal Services	Providing legal advice to CYPS
Strategic & Community Housing	Organising provision of long term temporary Housing Association accommodation for the family

Table 3.1 Professionals involved with the care of Peter

Although some are strategic in aim, frequently they are defensive in tone. They define, for example, policies and procedures for documentation and indicate how information should be shared. Responding to the guidelines and regulations are front line professionals who interpret them in practice alongside other competing

issues. It is here that the most significant decisions are made and where the main emphasis in this analysis is placed.

Bureaucratic policies/procedures can provide a comfort blanket or map for practitioners, from which, at times, it may be difficult for them to separate themselves. For, although policies/procedures appear to give direction, the guidance is very complicated and difficult to understand, as a result there may be times that practitioners may be left confused. The starting point is to recognise both the individuality of the child and his or her complexity. Although procedures provide a structure or an aide memoire; what they do not offer is a blueprint for every eventuality. For these reasons, there may have been insufficient concerns and difficulties raised in presenting a coherent account related to Peter when individuals involved were so diverse in their roles and organisational positions. Nonetheless, no matter where one works, one of the most important tools for serving the child/family should be to know how to raise and escalate concerns appropriately. The LSCB report states that:

"*The fact that children are on a child protection plan is an important signal to other agencies that they should carefully monitor their welfare*" (LSCB, 2009, paragraph, 4.1.9).

"It is important to reflect on the process which took place in the case of baby Peter. The majority of the members who attended the child protection conference were not specialists in child protection. Their function was to bring safeguarding awareness to their daily work with children (e.g. the school) or to work in promoting the children's welfare (e.g. Family Welfare Association). They do not carry the main responsibility for protecting Peter" (LSCB, 2009, paragraph, 4.1.6).

Although there were deficiencies in the care of Peter, the members who attended the child protection conference appeared to have had insufficient concerns, the issues illustrated in the above quote, emphasise their position. Social workers took responsibility for assessment, decision making and interventions, whilst other professionals took on the role of monitoring and information gathering. A key factor in many case reviews has been failure to record information, to share it, to understand the significance of the information shared and to take the appropriate action in relation to known or suspected abuse and neglect (DfES, 2004a). Thus, it is demonstrated here that perhaps the other members involved may have been

constrained by their lack of knowledge. Given that, there may be inexperience in practice. One of the biggest deficits of training in child protection and certainly of social work has been identified as the failure to get to grips with the complexity of service users and the reality of involuntary clients (Ferguson, 2004).

Peter's early demise was due, in part, to a failure in communication, because reports had not been provided detailing his previous admissions and attendances to A&E, nor were they sought. Usually, criticisms regarding safeguarding children are directed at social services. However, in recent years the realisation of the part played by others in areas such as healthcare and education, have proved vital to the wellbeing of children. Therefore, there is a link to A&E records. This was the case with Peter Connelly.

3.16 The link to A&E child records

It is generally recognised that A&E is the prominent emergency care agency (Laming, 2009; 2003). Therefore, the information that A&E records provides, relates to documentation, communication and integrated care, and is considered relevant to the safeguarding of children (DH and DfES, 2004b; DfES, 2004a; HM Government, 2010). When a child attends A&E, records are used at various stages of their investigation and treatment. Therefore, by sharing this information with other professionals, they are enabled to fulfil their respective roles in terms of promoting the wellbeing of children. In Peter's case:

"The doctor from the Child Development Centre (CDC) said that she advised Ms A to go to the GP or the hospital A&E if Peter did not get better. He was not examined by the GP. No reports had been provided of his previous admissions and attendances at the hospitals for possible non-accidental injuries, nor were they sought" (LSCB, 2009, paragraph, 3.71)

Inaccurate documentation is a serious problem (DfES, 2004a; HM Government, 2006, 2010). Inaccurate accounts can play a major part in children remaining unsafe. The LSCB report states:

"It is not possible to reach conclusions about the nature of the family's cultural beliefs from the limited information available in the records" (LSCB, 2009, paragraph, 1.3.2).

The history of protecting children from abuse has illustrated on many occasions the importance of good documentation (Laming 2003; 2009; LSCB, 2009). Moreover, Government documents, such as the Working Together to Safeguard Children (HM Government, 2006; 2010), the National Service Framework for Children (DH and DfES, 2004b), and Every Child Matters (DH, 2004a), deploy the language of safeguarding by asserting the right to good documentation in order to provide effective information sharing.

The Serious Case Review (LSCB, 2009) indicates that communication failures were extensive between health care teams, their members and other agencies involved in the care of Peter and were a result of :-

- Insufficient assessment/monitoring/review;
- Pervasive belief that injuries were caused by a lack of supervision and the child's behaviour;
- Inability to identify and take appropriate action;
- Delay in referral;
- Limited effort to engage Peter's father;
- Trust and responsibility placed in a family friend.

In Peter's tragic case, the demands made on social workers appeared to be impossible to meet. In recent years, social workers appear to be demoralised, over-stretched, and social work is struggling to be perceived as a durable, attractive profession. Widespread staff shortages seriously compromise the quality of frontline services (Ferguson, 2004; DSCF, 2009). If a social worker recommends removal of a child from the home they are villified; if they do not and an incident occurs, they are held personally accountable for the injuries or death almost as if they had assaulted the child themselves (Ayre, 2001; DSCF, 2009). If one is caught up in such a challenging situation, there are also added factors, such as fear of controversy, fear of getting it wrong, added to which is the issue of power. Furthermore, according to the Social Work Task Force' document (DSCF, 2009) although most social workers want to act appropriately, they are cautious.

Arguably, a great deal of bad decisions are possibly made because a social worker may get too involved in a case and loses objectivity (Ferguson, 2004). Nonetheless, over-burdened social workers, whose training often fails to prepare them adequately for the demands of the job, can feel undervalued (Ferguson, 2004). Therefore, it is argued, that it is the responsibility of all those who are charged with the safeguarding of children to communicate the true position of risk of harm through effective documentation (Laming, 2003; 2009; HM Government, 2010).

The current state of technology supporting the use of integrated children's systems is hampering progress (Laming, 2009). This is because professional practices and judgements are said to be compromised by over-complicated, tick box assessment recording systems that do not support reflective thinking and risk analysis.

3.17 Conclusion

This chapter has presented a review of the development of the current child protection process in England. There have been new laws and procedures, practice and policies which are of immense importance, but it is the robust and consistent implementation of practice and policies which keep children safe. Multi-agency investigations, core meetings and child protection conferences are all opportunities to discover the extent to which the parents /carers loved the children and are able to demonstrate their responsibility to care for and to protect the child.

These new procedures have been set up as a response of previous failures in procedures resulting in a tragic and well-publicised child death. Media reactions have stimulated the government to do something, but despite the identification of deficiencies in the systems of protection, the centrally imposed solutions, whether legislation policy guidance or revised procedures, prove ineffective at safeguarding children. These are significantly top-down, imposed solutions driven by central government. One persistent difficulty remains deficiencies in the communication by those front-line professionals required to protect children or to recognise warning signs that proved obvious in hindsight at the public enquiries.

This is particularly evident in the case of Peter, (Executive Summary-LSCB, 2009, p.17, paragraph.4.1.16) where those who were assigned tasks in the child

protection plan were not always invited or present; there was also a failure to be thorough and acknowledge or take urgent action. The most important hazard of poor communication between agencies in this case resulted in the untimely demise of Peter. Inadequate record keeping illustrates that the issues surrounding the safeguarding of a child may be severely restricted by the deficiencies in record keeping (Armstrong, 1996; DfES, 2004a; NMC, 2008; Laming, 2003; 2009; HM Government, 2010).

The formal report (Executive Summary-LSCB, 2009, p.19, paragraph.4.2.1) identifies the importance of documentation and information sharing for all agencies involved in the safeguarding of children. The report highlights an acute and chronic lack of effective record keeping, communication and collaboration. Therefore, in the case of baby Peter a unique opportunity arises to shape and develop practice. Notwithstanding, the work to safeguard children is progressive. It is too late to save children like baby Peter, although we can only endeavour to correct for others, what fundamentally failed him.

The nature of the research question, the literature review and the child protection process in England has provided a base on which to build the conceptual framework for the study. This thesis is on the interaction between front-line staff across professions and agencies charged with child protection tasks. The importance of the human element, for example, the staff values and perceptions of documentation and communication are the central concepts. The dynamics of the relationships between staff are clearly another important factor.

The following chapter therefore explores theoretical approaches that appear most relevant to understanding these professional interactions in order to develop a conceptual framework which explains these behaviours.

Chapter 4 Examination of conceptual issues - Social construction of everyday life

Introduction

The previous chapters evaluated pertinent literature in order to identify and organise relevant key ideas for the investigation. What has emerged is that the approaches used for documentation and information sharing derive from a shared knowledge base which is complex and multi-faceted. This chapter explores theoretical approaches in order to provide the best way to interpret these relationships. The primary objective is to devise a valid theoretical interpretation relating to documentation and communication in the child protection arena. The secondary objective is to explain gaps in information sharing research within and between colleagues in a health and social care environment. The chapter initially considers the work of Berger and Luckmann (1967) and Heidegger (1962) which has proved useful in explaining some of the issues. Consideration is then given to some factors that influence communication such as inter-relationships, professional perspectives and activities. This then allows for the development of a conceptual framework for interpretation. This chapter concludes with a summary of the main points.

4.1 Social construction

One explanation of how society shares a common understanding of reality is grounded in the everyday interactions between people. This epistemological position is best expressed in the work of Berger and Luckmann (1967) which explains and considers how social phenomena is developed in social settings, wherein groups construct knowledge for one another, collaboratively creating a culture of shared artifacts with shared meanings. This is a sociological theory of knowledge which mainly derived from phenomenological philosophical ideas (Heidegger, 1962), but it uses an interpretation of language construction originating from psychological approaches such as Vygotsky (1978) and Wittgenstein (Hacker, 1998). Berger and Luckmann (1967) suggest that when one is immersed within a culture of this sort, all the time, one is learning on many levels about how to be a part of that culture.

4.2 Berger and Luckmann

While Berger and Luckmann (1967) acknowledge the influence of the individual on society, they consider socialisation, or the way a person learns to operate in a social context to be in two stages; primary socialisation where the child learns from their family, and secondary socialisation where the individual learns through social interaction at school, work and with peers. Socialisation covers not just the basic norms, language system and behaviours appropriate to everyday life, but also the way that external reality is perceived. According to Berger and Luckmann (1967) people learn most from those who they regard as significant others and these influential people are identified through social interaction rather than being proscribed. This is a phenomenological argument, that the world in which human beings live is not just a natural objective phenomenon, but one constructed by a whole range of different social arrangements and practices, and so multiple realities exist. The phenomenological variety of constructionism of Berger and Luckmann (1967) is concerned with the everyday life world of individuals, how a person's experience takes the form of solid and enduring entities and structures. Their work focuses on the phenomenology of individual's experience, and emphasises people's perceptions and understanding. They argue that meanings are based on social interaction and communication, and that people act and react in their environment on the basis of the meanings shared with other people.

There are various professional groups within A&E settings, such as nurses, doctors and administrators who share some norms, language and behaviours. Through their professional training, social background and other antecedents they have different priorities and perceptions of the everyday world of A&E which are based on their professional knowledge, skills and experience. Although these groups of people share a common identity, activities or interest, in a child protection service they are not all in the same physical location. Nonetheless, the social group in question, the A&E staff and the LOCP group are interlinked, even though their social relations derive from the basis of a social structure of individual agencies. Another useful element of the Berger and Luckmann (1967) perspective that impacts on this group is the role of the significant other. This is not always the person with the highest formal authority, like a consultant, but may be the influential mentor or the high status colleague who can affect interpretation of

experience on an individual within a socially constructed reality. Therefore it cannot be assumed that all staff share the same meanings associated with the use of child records in A&E. Some will give recording and communication greater priority in their work than others due to variations in the way they perceive the significance of their role. Records have a subjective meaning which is not always concordant across the staff compiling and using them.

When the staff in A&E interact with other colleagues, they do so with the understanding that their respective perceptions of reality are related. Therefore, as they act upon this understanding, colleagues negotiate using their common sense knowledge of documentation and information sharing (Berger and Luckmann, 1967). Whilst there are different realities that may be commonly shared in the A&E world, as creatures of habit people continue to practise in a habitual way, so this makes them easy to predict. As a consequence of watching each other's habits they predict the other person's actions, hence standards that are passed on to them become representations themselves, thus authorship is lost and granted to a higher power. In the case of documentation and information sharing, they may be initiated by government legislation, policy and practice. If it could be said that reality is socially constructed, it follows that values are influenced by these human symbolic representations, but only through social interaction do records come to be presented as part of an object reality. Since concepts or mental representations symbolise actions taken, in the day-to-day real world of A&E, the members of staff are interacting together in a social system that has been formed over a period of time. Therefore, concepts eventually become habituated into reciprocal roles played by A&E staff in relation to the children, and subject to the effects of status, power and communication norms in that social context.

Given that instructions are transmitted down through a hierarchical process in agencies, because this impacts on the decisions made by staff reality no longer seems of their own construct, therefore it is reified and thus the process is taken for granted. As a result, common sense issues relating to documentation are no longer debated. Hence, information sharing for the protection of children becomes embedded in the institutional fabric of the day to day reality of A&E. For that reason, events become part of a big working machine, reified, and are no longer

examined for factual value. Nevertheless colleagues in a health and social environment may feel that by following a socially constructed process, uncertainty and danger which is important for their survival will be reduced, thus their behaviour becomes predictable (symbolic) so they share the senses of reality with others through language (Maslow, 1954; Berger and Luckmann, 1967; Garfinkel, 1967; Russell, 1991; Ricoeur, 1991; Schutz, 1997; Samavor and Porter, 1999).

4.2.1 *Language*

According to the work of both Blumer (1986) and Berger and Luckmann (1967), language is capable of transcending the everyday life altogether, it can span discrete spheres of reality such as symbolic interaction that are unavailable to everyday experience; therefore it can enable other colleagues to interpret and understand relevant documentation. This reflects the view of Hacker (1998) and Vygotsky (1978) that language plays an important role in the analysis of everyday reality because it links up common sense knowledge with a finite province of meaning (Vygotsky, 1978; Hacker, 1998).

4.2.2 *Knowledge*

All knowledge, including the most basic, taken for granted common sense knowledge of everyday life, is derived from and maintained by social interactions according to a social constructionist perspective (Berger and Luckmann, 1967). The social distribution of knowledge entails a dichotomy in terms of general and role specific relevance. The social stock of knowledge differentiates reality by degrees of familiarity. For example, my knowledge of my own occupation, as a PLHV is rich and specific, while I may have only very sketchy knowledge of the occupational world of other colleagues. Thus, it begins with the simple fact that I do not know everything known to my colleagues, and vice versa, and culminates in exceedingly complex and esoteric systems of expertise. However, as a PLHV who is responsible for sharing the information, it can be inferred that through my perception as a PLHV I define my world, create and re-enforce reality, both subjective and objective, by existing in a social environment shared with other human beings (Berger and Luckmann, 1967). Therefore, when we forget that we make our world, we allow ourselves to fall victim to apathy, and to the circumstance. Thus, when we do not trust that we have a stake, a voice, a right and

an obligation to share information in order to safeguard children, they suffer and we as products and creators all lose. This giving up of personal responsibility is expressed in the phenomenology of Heidegger under the distinction of inauthentic thought.

4.3 Heidegger

The work of the German philosopher, Martin Heidegger (1962), is an ontological inquiry into the ground of existence; he argued that phenomena reveal their meaning by their significance to people. He described how human beings were born into a world to which they are socialised to conform, the world of them (das Mann). Therefore, their chosen activities, the values and meanings they pursue, have been provided by various human cultures. He suggested that the world is the happening, it does not simply happen, it is determined by its comprehension of being, or existence, therefore man's being is not inert. He expressed the view that a certain kind of sense-bestowal existed and implied that phenomena also have autonomy. According to his work, people are making no deduction from the idea of phenomenology but they are reading the principle from its concretion in the research work. In his conceptual framing of authentic (self) and inauthentic (das Mann) thoughts he pointed out that human beings are defined by their self-understanding and the stand they take, as active participants in the world , being there ('Da-sein' - the nature of being always existing in relation to social location). Heidegger (1962) thus conducts his description of experience with reference to Da-sein and refers to this as care ('sorgen'). In the course of his existential analysis, he described how Da-sein, finds itself in the world amidst other things that is thrown into its possibilities. Thus there is a requirement to be responsible for one's own existence, and the need to take up opportunities as they occur. He argued that to be able to describe experience properly means finding the being for which such a description might matter. In this case it would be the care of children. In the real world of an A&E department, because members of staff are constrained by factors such as legislation, power, time, systems and processes which make people conform, they are submerged into an impersonal or inauthentic routine. Thus the influence of the routine everyday life on the assessment processes in A&E could impede the individual thinking for themself.

The basis of Heidegger's (1962) notions of authenticity and resoluteness on that is, those specific occasions when care is offered, authentic decisions made should derive from the unique assessment of each situation based on actuality. Therefore this depends on A&E staff escaping from the world of the environment which inhibits the individual's view. Children presenting to an A&E department may be seen as a succession of different categories of cases rather than as individuals, since staff, children and records are all operating inauthentically - working according to a socially constructed process. Part of the issue is that staff need to be able to identify the signs of what is relevant in the real world of A&E in order to practise autonomously (an authentic mode). However, unless staff can find ways to acquire control, by taking records, which are created in a discreet A&E social environment, and transferring them to a multi-disciplinary reality in a working situation, all of their decisions will continue to be made for them by the unnoticed forces of the cultures in which they work.

Whilst the area of safeguarding children is developing, with greater focus on better information sharing reflected in major legislation, policy and practice (Children Act, DH, 1989; Children Act, DH, 2004; Every Child Matters, DH, 2004a; HM Government, 2006), record keeping continues to be highlighted as being at fault. Although relevant measures have been put in place to improve documentation and record keeping, there has been no overall improvement (DH, 2004a; Laming, 2003; 2009; LSCB, 2009). Clearly the understanding of the sharing of information, its development and world view have evolved over the last three decades, but the issue has still not been fully addressed. Thus, it appears that a more comprehensive understanding of the subject is required.

According to a number of authors in the field (Heidegger, 1962; Denzin and Lincoln, 2005; Polit and Beck, 2008), the sharing of information is approached not as a world achieved by a process that is appropriate, but as a subject objectified in contradistinction of the real world of A&E. This view is supported by both Hacker (1998) and Vygotsky (1978) who argued that these forms of representations are essential to survival. Therefore, the terms that is assigned to information sharing reveal a hidden tendency to objectify the social construction placed on documentation that says simply that they are epistemologically prejudiced. In

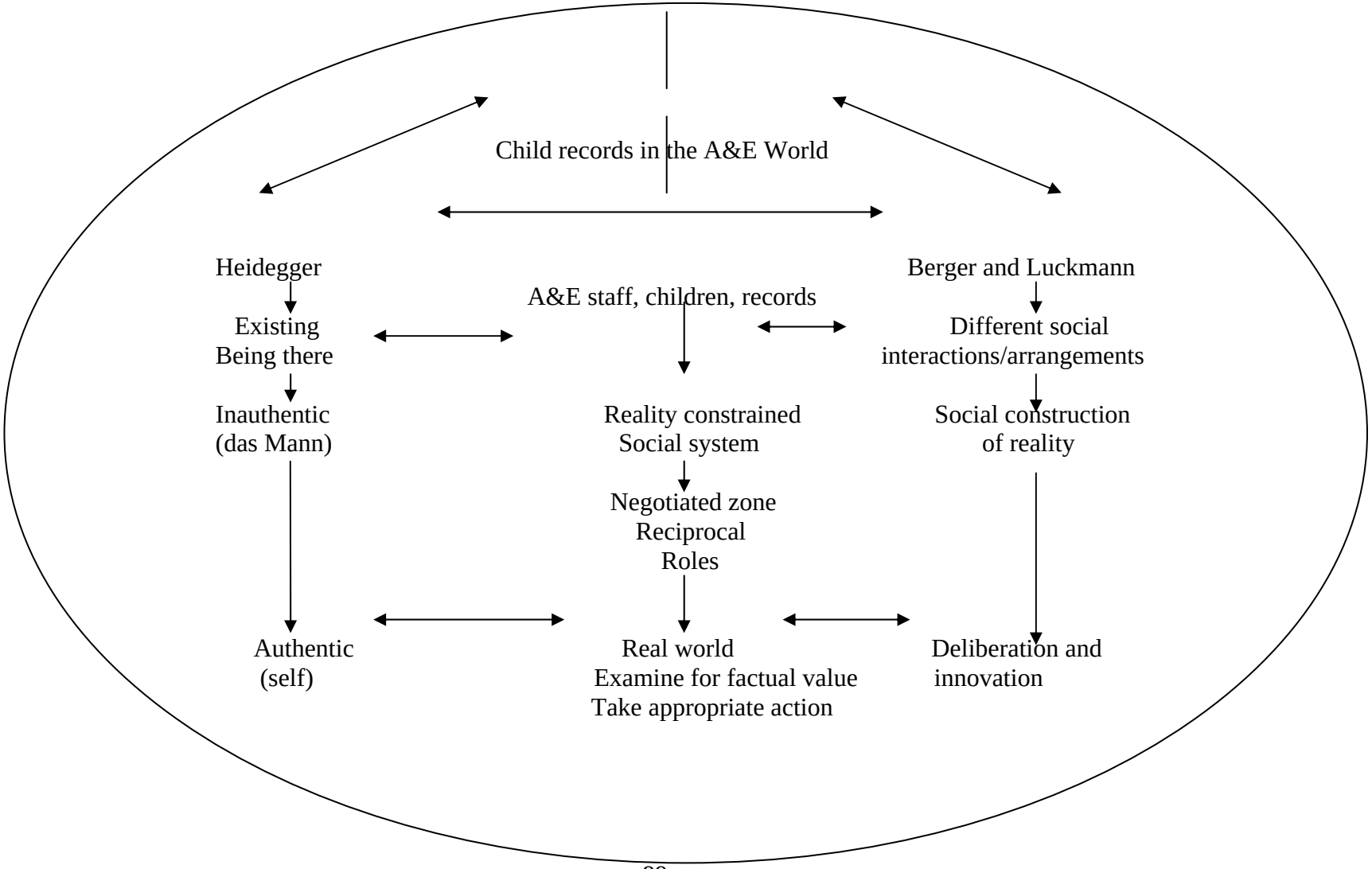
terms of Heidegger (1962), when information from child records is communicated to others, A&E is sharing these socially constructed data with other people who may give this different meaning, due to their different social location, since language and action are fundamental to existence.

4.3.1 *Language*

Heidegger (1962) took the stance that the language staff use to describe information sharing and the readiness with which they use it tends to carry their thinking along a predetermined or one-dimensional track. This ultimately obfuscates their understanding of who the presenting children to A&E are and indeed who they are themselves. Therefore, it lacks ontological sensibility and loses sight of the fundamental fact that this being (as all human beings) is defined by the nature of being always existing in relation to the social location. He argued that all that people understand, from the way they speak, to their notions of common sense, is susceptible to error, and so there are fundamental mistakes about the nature of being. He also suggested that these mistakes filter into the terms through which being is articulated in the history of philosophy.

The work of Heidegger (1962) and Berger and Luckmann (1967) allows people to logically move toward clarity and the illumination of the understanding of the social construct they placed on assembling, and the perceived associated value of communicating, information within and between social environments. Decisions and priorities are made sometimes inauthentically, on the basis of habituation, and also as a result of assumptions about a shared socially reality, where insufficient information has not been transferred. Heidegger (1962) and Berger and Luckmann (1967) assisted in the process of choosing an appropriate style of inquiry, as they served as clarifier and generator enabling the researcher to use analytical skills as thinker to examine the concept of the use of child records. These authors provided a wealth of valuable insights into the philosophical conception that relates to documentation and information sharing by colleagues. Shown below (**in Figure 4.1**) is an illustration of how the work of Heidegger (1962) and Berger and Luckmann (1967) links to the study.

Figure 4.1 Diagram of the connections of Berger and Luckmann and Heidegger to the study



4.4 Facilitating information exchange

In this research project, the PLHV's role, is that of communicator, since this role facilitates information exchange verbally and in writing to other colleagues. Therefore, the quality of a PLHV's communication is an important factor in safeguarding children. Thus he/she must be able to convey information effectively and accurately, as inaccurate accounts may lead to children remaining unsafe (DH, 2004; DfES, 2004a; DfES, 2006; Laming, 2003; 2009; NMC, 2008; Balls, 2009). Communicating in this study also involves A&E staff members such as nurses, doctors, clerical, healthcare assistants and managers who are the creators of the records, and colleagues in a health and social environment who are recipients of the information. Therefore, the process of informing others necessarily starts with a process of assessment and forms the basis for intervention by other colleagues and/or agencies.

4.5. Context of communication

Achieving and sustaining a reputation for quality and continuous improvement are both ethical and business necessities in the present healthcare environment. Therefore it is important to identify errors of child protection where difficulties exist in order to improve the communication process. So far, although there have been significant actions taken associated with documentation and communication, there have been no general improvements between agencies (Raffel, 1975; Carter, 1987; Haynes, 1988; Bentley, 2002; Laming, 2003; 2009; LSCB, 2009). Most important in terms of communication in this project are social and cultural contexts, since the importance of the human element on documentation is being addressed. Social contexts are the social settings within which different communications occur (Fielding, 1995; Burnard, 1997; Hugman, 2009). Cultural contexts are the prevailing norms and values of a social group, which have profound influences over a range of human behaviour (Fielding, 1995; Burnard, 1997; Sands, 2001; Higgs et al., 2005; Green, 2008; Hutchinson, 2008; Hugman, 2009). The issues here relate to meanings and truth, and the influential problems concerning the effect and impact of recurring child protection scandals on human behaviour. The associated meaning of things shapes how people act, consequently what goes on in the everyday life in an A&E department influences the way staff operate (Berger and Luckmann, 1967; Blumer, 1986).

According to Higgs et al. (2005) and Hugman (2009), during the communication process, such as when information is shared with others either verbally or written, this information may sometimes come from a variety of sources. Therefore, since an important part of any healthcare professional's job is to communicate successfully, health care communication skills involve merging knowledge gained from research into perception, memory, cognition and learning, with social skills (Sands, 2001; Alder and Rodman, 2003; Higgs et al., 2005). It has been suggested by Josebury et al. (1990) and Moss (2008), that multi-professionals in health and social sciences are expected to practise with integrity and personal tolerance and to communicate effectively across language, cultural and situational barriers. Drawing from sociological theorists, when information is shared from the source, acquiring, sharing, and processing information are critical activities in the decision making process (Berger and Luckmann, 1967; Garfinkel, 1967; Ricoeur, 1991; Schutz, 1997). Shannon and Weaver's model (1949) (see Chapter two) embodies the concept of an information source which has been widely adapted into the social sciences field (Fielding, 1995; Burnard, 1997; Baker et al., 2002; Alder and Rodman, 2003; Higgs et al., 2005).

Different types of information sharing have developed because of improvements in children services and several representations of information sharing are offered (DfES, 2006; DH, 2007; HM Government, 2006; DCFS, 2009). Consequently, in order for communication to be effective, it is essential to have a good understanding of the topic, because the information shared for safety and wellbeing of children should only be used with consent where appropriate and secure. In the event of being unsure advice should be sought. The communicator needs to be open and honest with the child/family, since information shared needs to be necessary, proportionate, relevant, accurate and timely (DCSF, 2008; DfES, 2004a).

4.5.1 *Nursing perspective*

Nurses fulfil a number of roles when they provide care. Thus, information sharing (communication) is integral to all nursing roles so this means communicating with a range of other disciplines. Although it is hard to say when the art of nursing began, if one thinks about it logically, it could be said that there has always been

illness and caring. Florence Nightingale (Nightingale, 1969) was instrumental in shaping the image of the nursing profession in the 1850s. She kept notes on her observations and used the information to establish the level of care provided and to improve care in areas that were considered sub-standard. The assumption here is that when nursing began communication was an important factor in nursing.

McCance et al. (1999) suggest that nursing encompasses a wide range of activities which changes over time, and that nursing is and continues to be an evolving practice. They argued that most of the theories of caring in nursing are grounded in humanism and can be easily applied to nurse practice. A similar view is held by other authors (Compton and Galaway, 2005; Payne, 2005; Coulshed, 2006; Howe, 2009), who suggest that, although no major theoretical frameworks that influence social systems have emerged to underpin practice in the last two decades, either nationally or internationally, the application of theory has been modified over time. These authors also refer to those approaches which are commonly found in core texts for practice, and argue that they have been subjected to re-definition and re-evaluation as social attitudes, values and beliefs change; therefore, they have particularly been examined for usefulness in relation to changes in legislation and policies which guide practice. However, in the latter half of the twentieth century a number of nurse theorists (Henderson, 1966; Orem, 1971; Watson, 1979; Roper, Logan and Tierney, 1980; Kings, 1981; Leininger, 1991; Parse, 1995; Roy, 1997; Neuman and Fawcett, 2002) created their own theoretical descriptions and definitions of nursing[15] that described not only what nursing was, but the inter-relationship among nurses, the patient and the outcome of health.

According to the World Health Organisation (WHO, 1948) care from a nursing perspective involves a combination of the following areas, promoting health and preventing injury. This is supported by Henderson (1966) who suggested that the nurse is concerned with both health and illness. This idea has been taken further by the Royal College of Nursing. In its published position statement Defining Nursing states:-

"Some of the purposes of nursing are to promote health, healing, growth and development and to prevent disease, illness injury and disability"(RCN, 2003, p.3).

[15] Shown in **Appendix 34**

A variety of programmes can be used for the promotion of health and this includes the sharing of information. According to the WHO (1948) and the RCN (2003) health promotion and injury prevention are not just focused on the prevention of disease. They are also focused on children's social and mental health and revolve around a philosophy of wholeness, wellness and wellbeing. The DH (1999a) refers to health promotion and injury prevention as important components of nursing, but they are also the responsibility of all health care professionals working within clinical practice (NMC, 2008). Thus, information dissemination is one of the most basic of the health promotion programmes. Accordingly the nature and quality of records depends on a variety of personal, professional and organisational factors both in the selecting and interpreting of evidence (Munro, 2004b; 2004c; Payne, 2004; Parton, 2006). Thus, employing a model could assist in identifying the part played by staff in selecting, recording and communicating information to other colleagues.

Naidoo and Wills (2001) argued that it is difficult to change health behaviours by using one approach and expressed the view that approaches need to complement one another. In line with this view Tannahill's model[16] (Naidoo and Wills, 2001) was utilised in this study as it could assist in identifying areas of child protection where difficulties exist in recording or extracting information. Despite its simplicity, this model describes health promotion as three interlinking circles that include health education, prevention and protection. It is generally recognised that the concept of information sharing is multi-faceted and not unique to nursing, because the ability to communicate with others is an essential attribute of human life all professionals are dealing with communication tasks in their daily lives.

4.6 Health Belief Model (HBM)

According to Becker (1976; 1978), the HBM model is a psychological model that attempts to explain and predict health behaviours. Considering that the behaviour of staff impacts on documentation and information sharing, this study is linked to the Health Belief Model (HBM) based on the three interlinking circles below (**Figure 4.2**). This postulates that health-seeking behaviour is influenced by a

[16] Shown in **Figure 4.2**

person's perception of a threat and the value associated with action is aimed at reducing that threat. Becker (1976; 1978) argued that health beliefs may reflect a lack of information or misinformation about health, which may include practices from different cultures as it focuses on the attitudes and beliefs of individuals. He draws attention to the major components of the HBM and suggest that they represent the perceived threat and net benefits. He argued that the key elements in the HBM account for people's readiness to act, and are spelt out in terms of four constructs: perceived benefits, perceived susceptibility, perceived severity, and perceived barriers. On the basis of Becker's (1976; 1978), work if one's belief is that effective documentation would promote a child's wellbeing, the perceived benefits would represent their safety. Thus the other three components could be applied to people's value and perception of documentation, since action may not occur unless the severity is perceived to be high enough to have serious implications for a child.

4.6.1 *The macro, meso and micro model*

The inter-relationships influencing documentation originate from the legal frameworks for safeguarding children at macro, meso and micro layers[17] and consist of structural and dynamic characteristics such as processes that interact, and in so doing the various levels are interconnected. Thus the effects of the guiding ideas behind this model are synergistic and involve interdependence between professionals and agencies. **Figure 4.3** illustrates the major components of information sharing, and factors which influence the sharing of A&E child records.

Having set documentation and communication in the context of different theoretical approaches, a framework with the scope to support the broad knowledge base, as well as the varied situations and contexts that occur in clinical practice, is required. So in order to fulfil the task of providing the best conceptual framework, having discussed some of the factors that influenced documentation and communication, some key theories relevant to practice are selected and reviewed. These are the needs, systems, and the ecological theories and their application to practice are considered below.

[17] Illustrated in Chapter 5, **Figure 5.2**

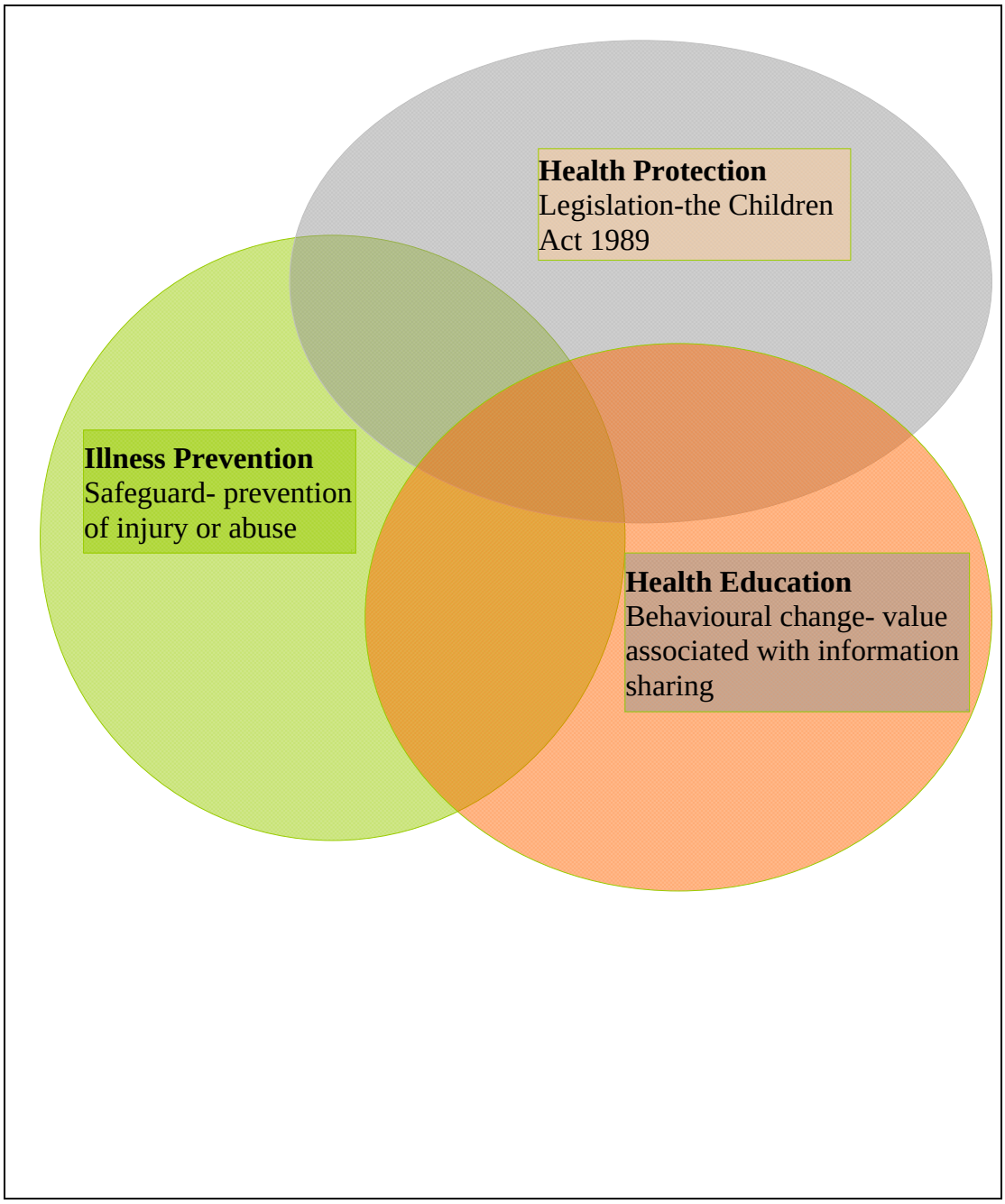


Figure 4.2 Tannahill's model of Health Promotion (1985). Source Naidoo and Wills 2001.

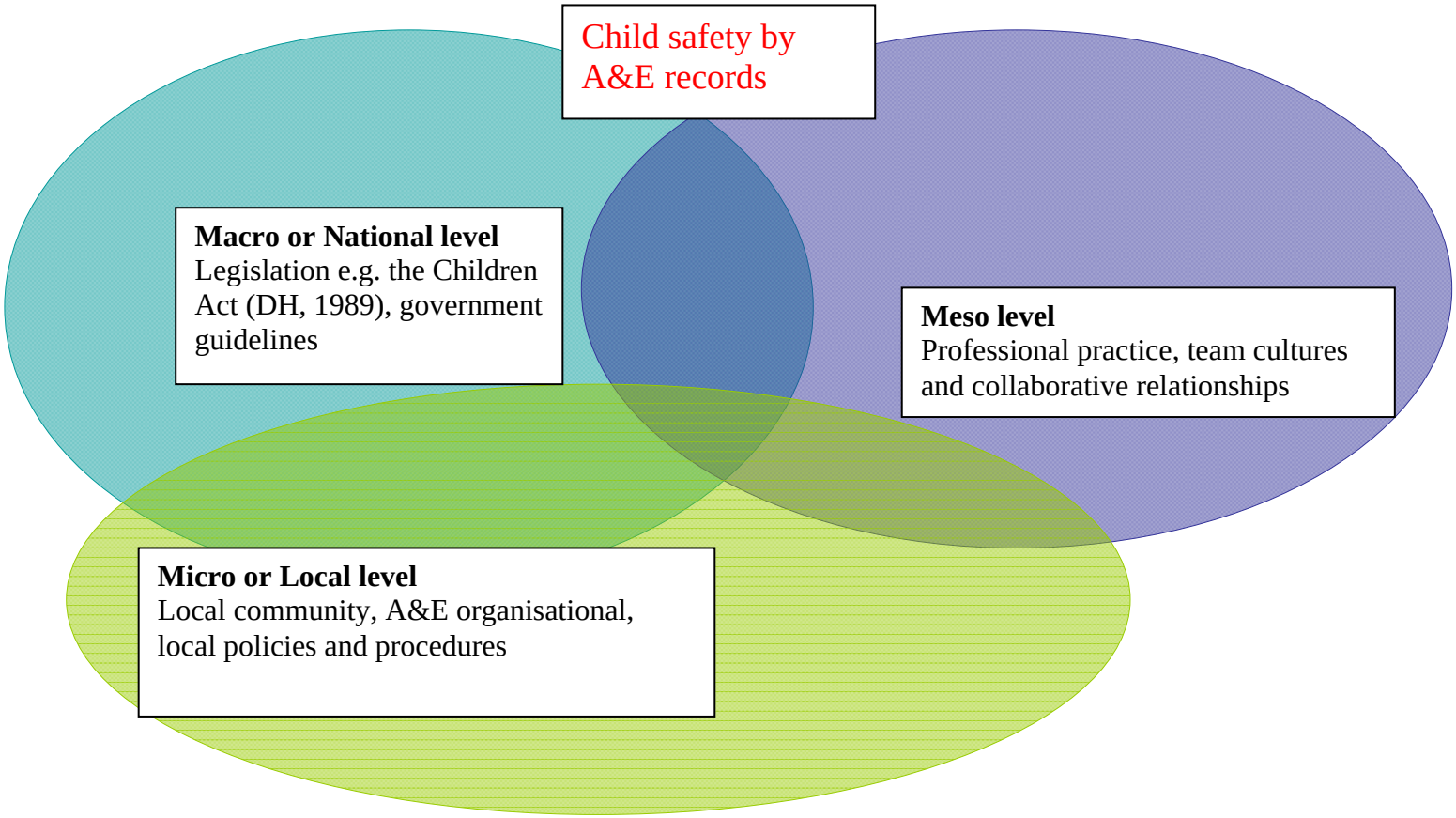


Figure 4.3 Conceptual Framework for the use of child records in A&E: The various terms in this model are linked to process, structure and interrelationships that influence this study.

4.7 The Needs Theories

The work of Roper (1983), was developed from the theories of the psychologist Maslow (1954) and his hierarchy of biological needs, supports, to a degree, the work of other nursing theorists such as Henderson (1966) and King (1981), and their notion that communication is closely linked with physical, social and psychological needs. Government policy documents (DH, 1989; DH, 2004; DH, 2004a; HM Government, 2010) identify competing needs (eg. professional, legal, parent and child needs) associated with information sharing; therefore understanding needs is fundamental to promoting the wellbeing of children. As a result information is shared so that an assessment can be undertaken in order to consider specific areas of the child's needs. This information is drawn and used as part of the analysis and decision making process and shared with the appropriate agencies (DH et al., 2000).

According to Maslow (1954), his model serves as a framework for assessing behaviours, and assigning priorities to desired outcomes. Maslow's (1954) model implies that human needs and their satisfaction are common denominators in any relationship, because satisfaction of needs motivates every type of behaviour. Maslow's (1954), human needs are ranked on five levels of an ascending scale. This is according to how essential the needs are for survival. In his proposed hierarchy of individual needs[18] he emphasised the importance of understanding why people work and what they communicate about. However, each person's needs and the way in which they react to those needs are influenced by the culture with which the person identifies. For example, the ways in which people think and feel about themselves are profoundly influenced by their position within any group (Heidegger, 1962; Kasl and Mahl, 1965; Berger and Luckmann, 1967). Although Maslow (1954) holds the view that most people have the same basic needs, he claims that, within any group, an individual needs to feel valued both as a worker and as a person, and he believes that from these two factors most people gain their sense of self-esteem. In other words, a person who has no respect from peers and has no sense of belonging and companionship is unlikely to achieve actualization

[18] Illustrated in **Figure 4.4**

and self-respect. Maslow (1954) claims that ability and self-worth determines motivation and argues that innate needs motivate a person to seek fulfilment of those needs.

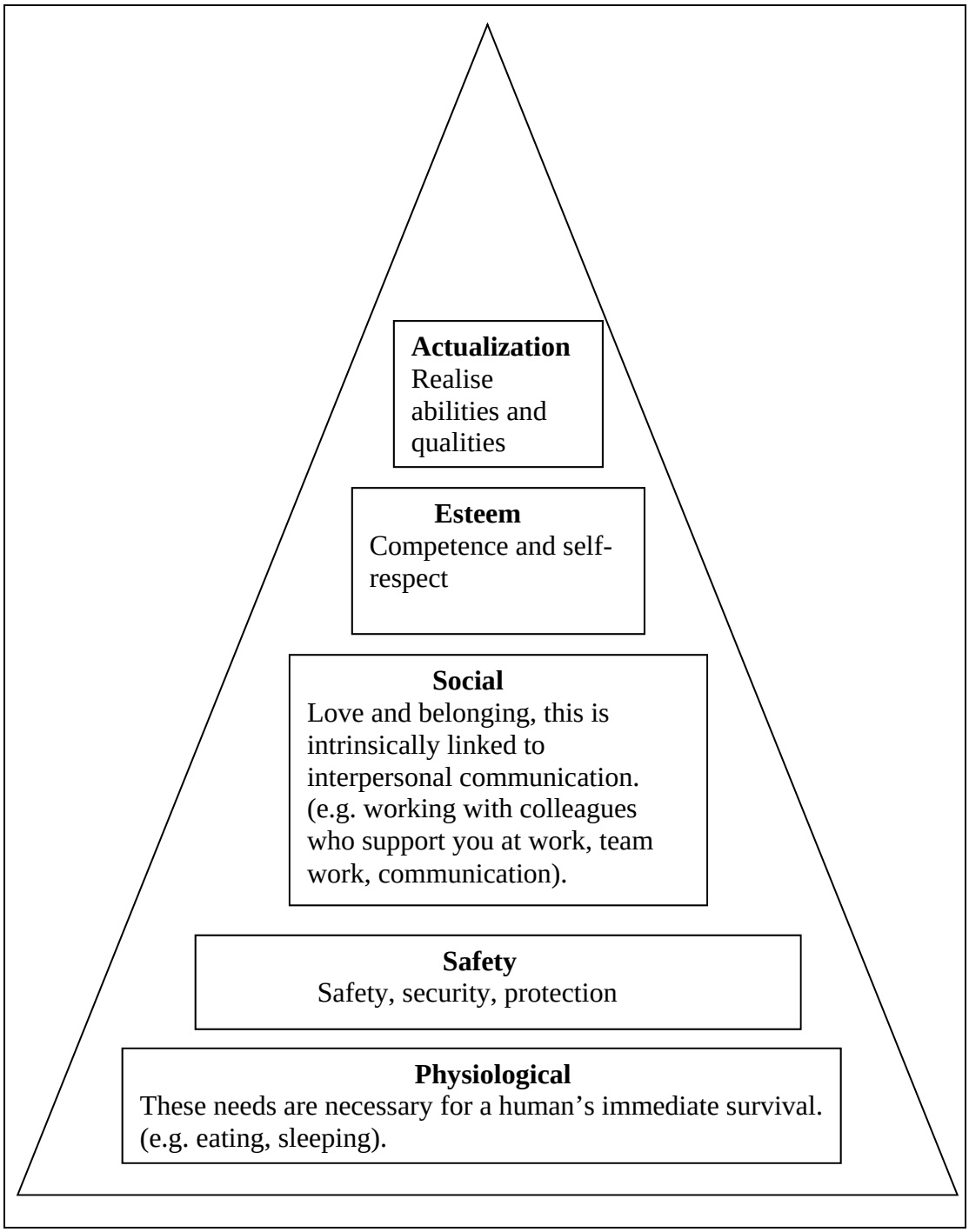


Figure 4.4 Adapted from Maslow's (1954) hierarchy of needs.

Rogers (1957), on the other hand, suggests that if people are deprived of their basic physical needs, if they have no confidence in their abilities, if they are isolated

from others, or if they are living under threatening circumstances, they may continue to survive, but it will not be as fulfilling a life as it could be. Therefore, he implies that self-actualization will not be achieved if difficulties exist in recording, extracting and communicating information.

The work of Fielding (1995) suggests that from Maslow's (1954) model, although there are other areas, two broad overlapping areas of communication needs for health workers are identified. He describes these areas as task-oriented and performance-oriented communiqués.

(1) The task oriented communications in this study are:

- the creating and sharing of records, undertaken by services such as A&E for formal functions of recording evidence for communication of information with others;
- verbal or written communication which addresses the execution of PLHV's role and relates to information sharing;
- feedback on children's care outcomes which may carry other evaluative data (DH et al., 2000; DfES, 2004a; DCSF, 2008).

Fielding (1995) refers to verbal, non-verbal or written communications as task-oriented interactions and argued that these address issues, relating to the performance of the health worker's role. He also expresses the view that performance oriented contacts relate directly to the self, either professionally or socially. Fielding (1995) further suggests that aspects of task oriented communiqués, such as information sharing, overlap with performance oriented communications, because the latter includes relationship building conversations and other contacts where the primary source is social rather than task oriented.

(2) The overlapping aspects of the performance-oriented communications and the task-oriented communication, relating directly to the self either professionally or socially are:

- the nature and quality of records depends on a variety of personal, professional and organisational factors both in the selection and interpretation of evidence.

A key element in the primary source of building relationship dialogues and other exchanges in this project is social interaction. According to Fielding (1995) evaluative responses are a key component in social communication, and whether the reactions are professional or social they are judgmental in nature therefore they affect people's behaviour.

The main feature of Maslow's (1954) model is that lower needs must be satisfied before the higher needs are addressed. Maslow's (1954) model indicates that if people have poor self-worth or are working in worrying situations they are unlikely to achieve self-actualization, since some moral issues such as a person's self-esteem may be ignored. As a result, Maslow's (1954) model does not appear to accommodate the feelings and opinions of either the creator or recipients of the records. According to the work of other authors (Josebury et al., 1990; Higgs et al., 2005; Moss, 2008), communication is only effective if it is clearly understood. The issues in this project are multi-faceted, and multi-agency communication is highly complex since each agency has its own management hierarchy and needs. For those reasons the needs theory may not achieve the required approach that is relevant for this study. Therefore, using this model would seem to be unsuitable for such a difficult area as safeguarding children. **Figure 4.5** below illustrates how Maslow's (1954) model could be utilised for the sharing of information.

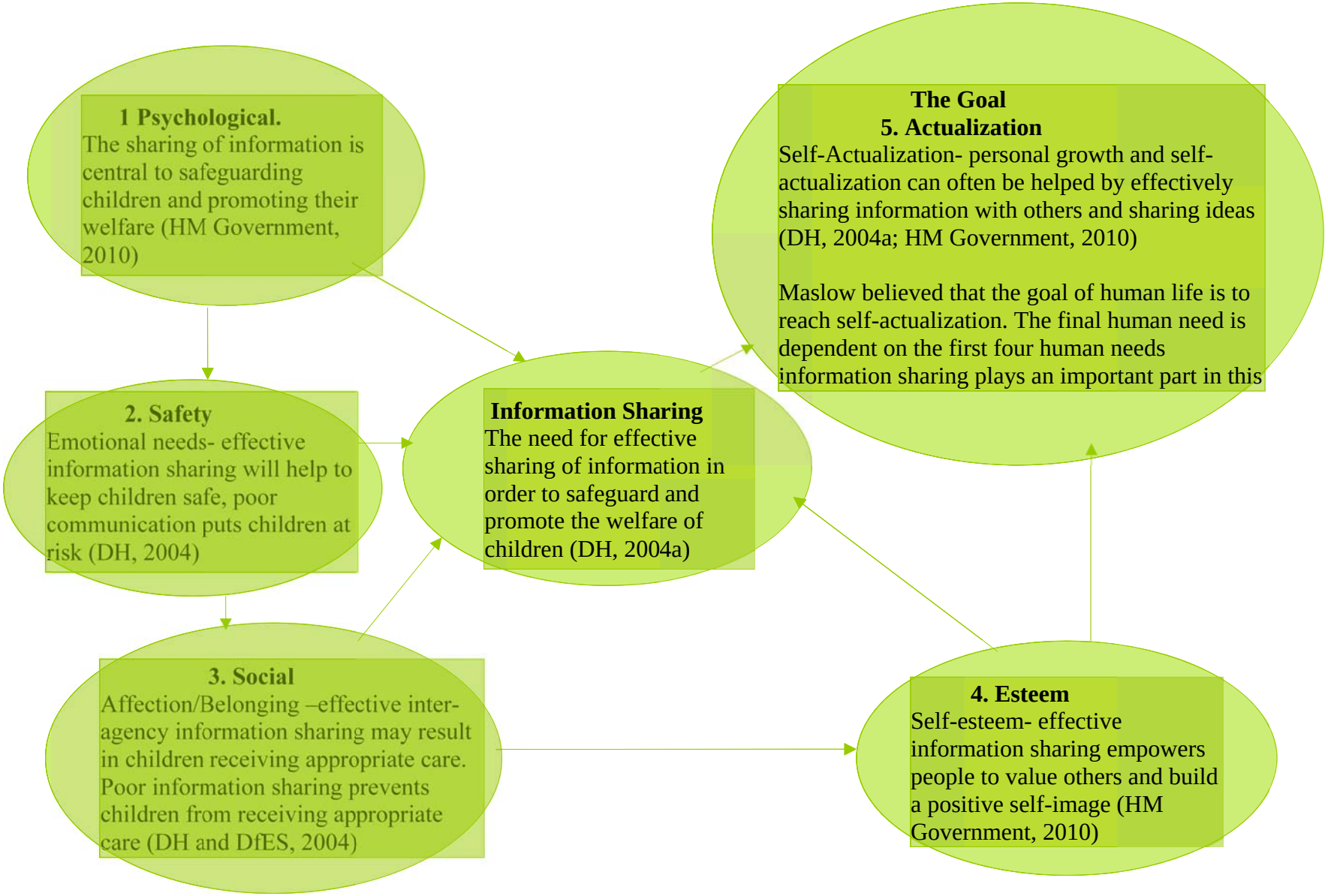


Figure 4.5 Illustration information sharing. Source: Maslow's (1954) hierarchy of needs.

4.8 The Systems Theories

The basic concept of a general systems theory was proposed in the 1950's, by von Bertalanffy (1969). He argued that it provided a common method for the study of the examination of inter-relationships, societal and organisational patterns; hence he introduced it as a universal theory that could be applied to any field of study. Kuhn (1970; 1974) concurs with this view and describes systems theory as the trans-disciplinary study of the abstract organisation of phenomena, independent of their substance, type, spatial or temporal scale of existence. He takes the stance that rather than being an end in itself, it is a way of exploring things. Thus it investigates both the principles common to all complex entities, and the models which can be used to describe them. He also suggests that it is an internally consistent method of scholarly inquiry that can be applied to all areas of social science, as it offers a well-defined vocabulary to maximise communication across disciplines (von Bertalanffy, 1969; Kuhn, 1970; 1974).

The aim in this study is to better understand what is going on in an A&E environment relative to documentation and the care of children when they present to emergency services. The intricacies associated with documentation are multi-faceted and complex; therefore not all of its difficulties are accessible to direct observation. As a result, the factors requiring investigation would not be immediately apparent as they are much more complicated than they appear in the simplified diagram shown below in **Figure 4.6.** For that reason the issues relating to this project are more closely related to the Black Box theory (Ashby, 1957). The concept of the black box describes the difficult nature of the complicated systems being studied. Pask (1970) argues that any situation that is complex and where there is difficulty gaining insight can be described as a black box; because the issues involved are complex and cannot be seen solely in terms of input and output. Thus using the systems theory may not successfully achieve the task of providing an appropriate conceptual framework required for this study.

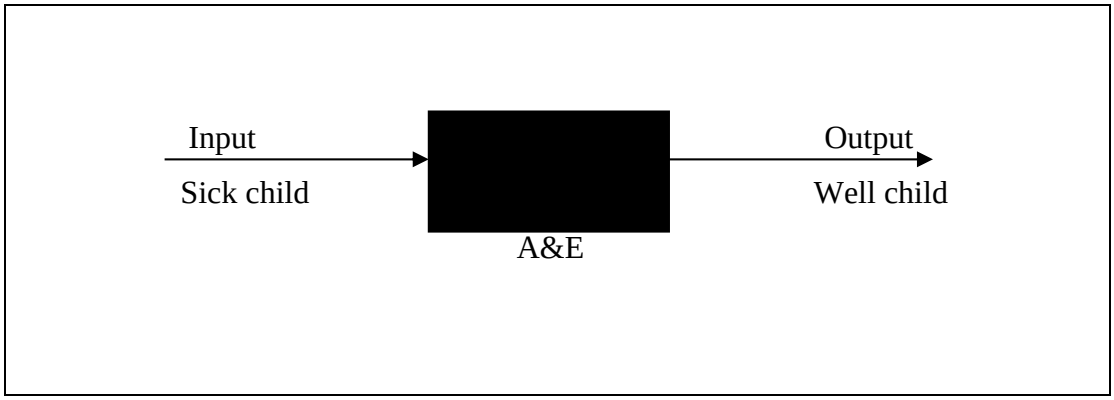


Figure 4.6 Source: Ashby 1957

4.9 The Ecological Theories

The work of some authors in the field (Bronfenbrenner, 1979; Allen-Meares and Lane, 1987; Naess, 1990; Haeckel, 1992; Ungar, 2002; Begon et al., 2005) claim that the human ecological theory is probably one of the earliest theories associated with matters concerning the family unit. They argued that the ecological perspective could be traced back to biological theories that explain how living beings adapt to their environments. Hence, unlike most behavioural and psychological theories, ecological theories focus on inter-relation transactions between systems. Consequently, the human ecological theory stresses that all existing elements within an ecosystem play an equally important role in maintaining balance of the whole (Hutchinson, 2008; Gilbert and Epel, 2009; Jorgensen, 2010; Brown, 2010). The human ecological theory is well established in social sciences, and contains many new and evolving components. Siporin (1975), Maluccio (1981), Garbarino (1982), Gilbert and Epel, (2009), and Brown (2010), claim that as people begin to realise how the natural and human created conditions affect their behavior, they recognise how individuals and families in turn, influence these situations; therefore in human ecology, the person and the environment are viewed as being interconnected in an active process of mutual influence and change.

In line with this view, both Sands (2001) and Ungar (2002) refer to the ecological approach as taking a holistic view of relationships of structural, physical, life events and research work. They suggest that the systems theory was expanded in the 1960's and 1970's based on an ecological approach to incorporate social

elements of the interactive process. Thus studies of social support and healthcare are described as part of an ecological understanding of the relationship of the individual to the environment. According to Allen-Meares and Lane (1987) the ecological approach has strength, because it is open, interactive, inclusive and potentially culturally sensitive. Therefore, the ecological perspective has emerged as the most comprehensive unifying framework for this study, as it draws from ethology, ecological psychology and ethnology.

4.10 Conceptual Framework

As suggested by Bronfenbrenner (1979), Naess (1990), and Haeckel (1992), environments may be the natural world, reality as constructed by humans, and/or the social and cultural milieu in which a human being exists. Therefore, as this study sought to address the importance of the human element, on documentation, the diagram in **Figure 4.3**, is used to show how processes, structure and inter-relationships come together and overlap in this study. In this theoretical framework, biological, social and physical aspects of documentation are considered within the context of their environments.

Therefore, by using this framework for the study, the researcher was able to gather data giving equal emphasis to the perspectives of the diverse staff that use the information child records contain, their environment (A&E) and their interaction. The fact that data was collected in relation to all the variables made the approach holistic. Thus, the inflexibility which can accompany a one theory approach was avoided, because there was provision for the audit of records, focus group discussions and observation data. Stevenson (1998 p.19) says of the ecological approach 'though it is theoretical it is very practical; it provides a kind of map to guide us through very confusing terrain'. Therefore, it has the ability to be flexible and adapt to changing social policy, and to work with other professionals from overlapping theoretical bases.

4.10.1 *Reflection on the number of theoretical perspectives referred to in this chapter.*

When I was considering a conceptual framework for the study of the use of A&E child records, because the outline of theoretical perspectives embodies what it

means to be in the world and my understanding of being there; the difficulties of deciding on the use of theoretical concepts and the integration of several approaches became apparent. Therefore, I drew on my past experience and my reading of different literature. As I reflected, I was fascinated by the various techniques devised by social scientists for understanding the lived experience. Thus, it was intriguing to find that the use of different theoretical perspectives illuminated the answer of finding an appropriate conceptual framework. At this point I reflected on the reading of different literature by entering into social theory, commencing with the theoretical perspectives considered for this study as outlined below.

- Hermeneutics, this is the philosophy of interpretation and is concerned with how one can interpret the here and now as well as other phenomenological approaches (Heidegger, 1962; Gadamer, 1976). It provided me with an approach through which as a researcher I was able to achieve congruence between philosophy, methodology and method. Hermeneutics also enabled me to move forward from a superficial grasp of the entire text, to a deeper understanding, of the text in relation to the whole and the complete text in relation to its parts (the hermeneutic circle).

- Berger and Luckmann's (1967) text on the social construction of reality, delves into much of the detail behind the idea that reality is socially constructed. This is to say that our individual realities are formed by our societal cultures. Building on the premise that most (if not all) of the knowledge we have, both objective and subjective comes from the society that we live in. These authors took me on an interesting journey from the state of humanism in individuals, to the process of primary and secondary knowledge that then developed into both society and institutions creation of typifications. Their work indicated that we create and re-enforce reality, both subjective and objective, by existing in a social environment shared with other human beings. Therefore when we, human individuals, view the world as pre-ordered, we lose the ability to process our role and impact upon that society. Although the work is generally centered upon the sociology of knowledge, it is more or less just a description of how this

knowledge encompasses the role of humanity in society, therefore as a consequence the lack of awareness, impacts on social environments.

- Heidegger's (1962) approach, claimed that man as beings have the freedom to choose how they live in the world. His belief encompasses both subjective and objective features of reality. His concept also denotes how we sense ourselves in situations. Given his opinion, of which I believe to be a good viewpoint, I can accept Heidegger's phenomenological argument that we are constantly aware of other subjects in our everyday dealings with artificial objects, and his ontological argument that our subjectivity gets some of its character from out relations to other subjects. According to Heidegger we are situated in the world living in a certain way with others. Thus our being, in Heidegger's view, is always being affected and that is how we find ourselves.

- The conceptual perspectives on caring as described by Gadamer, (1976) and McCance, et al. (1999) supports a hierarchy of theoretical development with a theological context that embraces the work of existential philosophers such as Martin Heidegger. These perceptions open doors to an understanding of the impact of wider social processes upon individuals and social groups. These were useful approaches that focused on healthcare comprehensively by concentrating on care that is collaboratively and cooperatively provided by relevant health disciplines. Therefore, to be effective, it is important to deconstruct our ways of knowing and understanding of the influence of the values and philosophies forming the foundation of our practice and research.

- Maslow's (1954) self-actualizing approach is based on the concept of needs. However, the basic model is that the higher needs in his hierarchy only come into focus once all the needs that are lower down in the pyramid are entirely satisfied. The main problem with Maslow's approach is that individual needs are instinctive; therefore questions of social interaction and culture are totally downgraded.

Having reflected on the theoretical perspectives above I acknowledged that deeply embedded in my conscious mind were my values and beliefs that are based on my own subjective understanding. I accepted that I believed that the theories that best support the use of child records in A&E are grounded in the critical perspective focusing on ethics, power, and the lived experience. As I reflected on the number of theoretical perspectives, I also recognised that in order to incorporate some of the ideas from different philosophers into the construction of my current comprehension careful consideration was required. Therefore I began to question my beliefs, values, and assumptions from both an intellectual and emotional point of view. Subsequently, I made an attempt to embrace my own unique experiences, emotions and history in order to ensure that my values and beliefs were not limiting me in anyway thereby preventing me from understanding the influence I had on the study.

As a researcher I can only view my world through my own perception, hence my background as a PLHV, influences the way that I am investigating the use of child records by my reflection of the past and anticipation of the future. Therefore, my ability to reframe, empathise and consider what life is from another perspective and make logical inferences from this new point of view was important. As a result I found my conscious state of mind in a position of constant change, because my subjective knowledge began to illustrate several challenges that I faced in providing an appropriate conceptual framework for the study. Nevertheless, as I carefully contemplated and weighed the theoretical perspectives and their purposes from different vantage points, I gained confidence in my ability to choose an appropriate framework and from this assurance; I was empowered to try new philosophies, beliefs and ideologies, for example Berger and Luckmann’s (1967) and Heidegger's (1962).

From my reflection, I understand that as a researcher I am part of the process of the research, and realised that the process of identifying a framework for this study depended on my personal experience in practice. Subsequently reflecting on the situation and the different theoretical perspectives required me to bring my emotions and reactions to the conscious level and incorporate them into the clinical care process. Overall the differing theoretical perspectives encouraged and allowed

me to understand the rich and complex nature of the use of A&E child records (see also reflexivity Chapter 5 and reflective journey Chapter 10).

4.11 Conclusion

This chapter has explored theoretical approaches as it applies to the social construction of processing a vulnerable child through the modern child protection process in England, and has been very helpful in structuring and organising ideas in this study. Theoretical and social issues transcend the day-to-day world of information sharing in the twenty-first century within a health and social environment. So the approaches used in information sharing derive from a knowledge base which is multi-faceted; and communication is based on cultural, social and psychological systems and is highly eclectic. Therefore, the challenges in documentation and information sharing in this project are not only influenced by inter-disciplinary differences but also by inter-organisational, and inter-cultural differences which emerge in verbal and written communication.

Although language is the principal medium through which social reality is produced and reproduced in everyday life, communication failures are extensive between multi-agency/multidisciplinary teams in terms of safeguarding children (Laming, 2003; 2009; Higgs et al., 2005; Harraher, 2009; Balls, 2009; Hugman, 2009). The information hierarchy is so extensive that many concepts (such as information sharing by means of the use of child records in A&E) remain highly abstract and incomplete. The naïve notion that interaction is merely the transmission of information perpetuates the process of communication. Therefore, a framework with the scope to support the broad knowledge base as well as the varied situations and context that occur in clinical practice was required.

While a variety of theoretical frameworks provided for knowledge relevant to this study, unlike most behavioural and psychological theories, ecological theories concentrate on inter-relation transactions between systems. It emphasises that all existing elements within an ecosystem play an equal role in maintaining a balance of the whole. As a result the ecological theory provided the best conceptual

framework to inform this study[19] since all existing elements play an equal role in maintaining balance of the whole (documentation). As a result this framework is based on the premise that the social construct people place on documentation is inherently part of how the participants perceive their roles in selecting, recording and communicating information. Having established a clear focus for the study, what was now required was the selection of an appropriate methodology. The next chapter addresses the choice of methodology.

[19] See **Figure 4.3**

Chapter 5 Methodology

Introduction

This chapter outlines the approach taken to fulfil the aim of the study and presents the theoretical issues that underpin the research methodological approach. The work of various authors in the field (Polit and Hungler, 1999; Denzin and Lincoln, 2005; Mays and Pope, 2006; Polit and Beck, 2008) indicate that the goal of qualitative research is the development of concepts, which help us to understand social phenomena in natural (rather than in experimental) settings, giving due emphasis to the meanings, experiences and views of all participants. Crabtree and Miller (1999) express the view that in such research, there is no pre-packaged design. In line with this view Gadamer (1976) argued that there is no value free or bias free knowledge and so the researcher identifies his/her own values and biases, articulating his/her own position in relation to the difference between existing theories. Within this research I am aware that my personal, professional interest and concerns have influenced and will influence each stage of the study. I am also aware that there are potential problems with human subjectivity and that multiple realities exist.

Methodology is the way research is managed according to the principles and procedures of inquiry in a particular discipline. It is the processes by which the researcher obtains knowledge (Lincoln and Guba, 1985; Denzin and Lincoln, 2005). Case study research typically entails the intensive study of a small group, or of individuals sharing certain characteristics in depth. Therefore, it is not preoccupied with breadth as in quantitative research, as qualitative findings tend to be oriented to the contextual uniqueness and significance of the aspect of the social world being studied (Polit Hungler, 1999; Denzin Lincoln, 2005; Polit and Beck, 2008).

5.1 Research issues

This study takes place in the natural setting of an A&E department. It focuses on the use of child records as a means of improving documentation and information sharing with reference to child protection by examining the perspectives of the staff that use these records. Data conveying meaning can provide rich insight into

human behaviour such as views, opinions and understanding (Guba and Lincoln, 1994). Unlike that of physical objects such data cannot be understood without reference to the meanings and purposes attached by the professionals who share the information contained in the records.

Therefore, a naturalistic approach is chosen, as it provides a logical structure for holistically exploring reality through the eyes of the participants. This approach was also chosen, because the ultimate aim of this inquiry is to gain understanding about the use and purpose of child records, with the goal of generating holistic and realistic explanations by the best process, thereby contributing to knowledge. This approach offers flexible evolving procedures throughout the research process that will enable the researcher to uncover the story of how the records are used. It allows for development of theory that takes into account local conditions (Glaser and Strauss, 1967; Bodgen and Bilken, 1982; Lincoln and Guba, 1985; Guba and Lincoln, 1989; Patton, 1990). The in-depth probing nature of qualitative research is well suited to the task of answering the research question and is more informal and therefore less scientific terms are used than in the case of a scientific approach (Polit and Hungler, 1999; Denzin and Lincoln, 2005; Mays and Pope, 2006; Polit and Beck, 2008). Therefore, the research question is more amenable to the qualitative inquiry which is in keeping with the qualitative philosophy and gives the opportunity to balance both professional and personal issues.

The part played by a qualitative researcher in the production of data is crucial since the researcher's own perspectives influence the research (Melia, 1982; Lincoln and Guba, 1985; Patton, 1990). It has also been stated that an important characteristic of the human mind is the ability to generalise, to recognise regularities, and to make predictions based on observations (Polit and Hungler, 1999), and it is by using their senses and mental faculties that people gain knowledge. It has been argued that the aim of knowledge is not to uncover the nature of the external world, but to understand how they come to know the world as they do (Schutz, 1967; Husserl, 1970; Zinman, 1978; Hammersley, 1992). Because of this position reality is not a fixed entity, it changes and develops (Porter, 2002; Denzin and Lincoln, 2005). Thus the particular instance of practice is negotiated between a person's

professional and personal knowledge. Therefore, they guide and shape the decision of what is acceptable and appropriate for the study of the use of A&E records that corresponds most closely to the view of the world and of reality. This reflects the view held by some authors (Polit and Hungler, 1999; Denzin and Lincoln, 2005; Mays and Pope, 2006; Polit and Beck, 2008), who argued that organisational culture and ethical issues together with the style of a professional, their values and beliefs, their attitude, their understanding, their subjective perceptions, and their common sense knowledge all shape the way they think. Therefore, their understanding changes and develops according to their experiences and the social context within which they find themselves. In this study I am working with other professionals who share the information child records contain. It is in this context that we can understand the significance of social interaction with the multi-professional staff in A&E and other agencies and my understanding and preconceptions of reality.

Nevertheless, despite the obvious benefit of my experience, there are limitations if experience is used as a basis of understanding, when considering the sharing of information by means of records. First of all, my individual experience may be too restricted to develop generalisations. As a PLHV, I may have noticed, for example that two or more records used for the purpose of information sharing in order to safeguard children follow similar patterns. Although this observation may lead to interesting discoveries with implications for child protection interventions, my observation and experience may not justify widespread changes within the area of child protection. Another limitation of experience as a source of knowledge exist in the fact that the same event is generally experienced or perceived differently by two individuals. My own previous experience of the use of the records represents a familiar and functional source of knowledge of practice, which is inevitably biased.

However, in this study the issues are whether it is possible to fully understand other people's experiences. For example, in the completed research report, the understandings of the multi-professionals would have been filtered through my understanding as the researcher, and therefore, it would be very difficult to tell the degree of distortion that has occurred in the process. Nevertheless, the voices and

explanations of those under study are the key to understanding the phenomenon of interest, and their subjective interactions are the primary means of accessing them (Porter, 1993b; Crabtree and Miller, 1999; Porter, 2002; Polit and Beck, 2008). Therefore, the approach as a participant researcher, who is part of the action, has been to adopt an epistemological position which is socially constructionist, but is also derived initially from the philosophy of Martin Heidegger (1962), whose philosophy about the way human beings or entitites exist is ontological, rather than epistemological, in that it is a study of the nature of being. For practical research purposes this is too complex for the nature of this enquiry, but some basic principles such as: da-sien (German there-being) or that being can only be understood in its social location that utilised authentic and inauthentic decision-making.

5.2 Epistemology

It is the philosophical theory that is concerned with the nature and scope of knowledge. This is both objective and subjective because it results from the inquirer's interaction with those being researched, and findings are the creation of the interactive process (Denzin and Lincoln, 2005; Polit and Beck, 2008). This study utilises the premise of social construction of reality (Berger and Luckman, 1967) in order to gain meaning of the participant's own reality of their world. Since the reality of the use of child records lay in the participant's own construction, the investigation is therefore more accurately social constructionist (Berger and Luckmann, 1979). For that reason the seminal work of Berger and Luckman (1967) is particularly influential in utilising the epistemological approach, given that the voices and explanations of those under study are the key to understanding the hermeneutic content of the social constructs, or data, and subjective interactions are the primary means of accessing them. The epistemological position is naturalistic and intuitive in that it assumes that knowledge is maximised when the gap between the inquirer and the participants in the study is minimised. As a result an epistemological position has been utilised in order to grasp the socially constructed meanings. In addition, this approach allows analysis of the evidence that impacts on the creator of the records, and assists in explaining the potential difficulties embedded in the social processes and environments in which records are created and shared. Subsequently, these meanings could then be reorganised

into a social scientific language. Therefore, the epistemological assumption is appropriate for this study as it overtly acknowledges and builds upon the premise of the social construction of reality (Berger and Luckmann, 1967). From this standpoint, information can be seen to be both individually and socially constructed.

5.2.1 *Sharing of records*

The creation and sharing of child records is undertaken by services such as A&E for formal functions of recording evidence and conveying that information to others. Therefore, both documentation and communication are particularly important for services charged with the safeguarding of children. This ethos is echoed both in the Government's Every Child Matters strategy (DfES, 2004a) and the NSF for children (DH and DfES, 2004b). The process of information sharing necessarily starts with a process of assessment and forms the basis for intervention by the assessors, colleagues and potentially other agencies (DH et al., 2000). However, the nature and quality of the records will depend on a variety of personal, professional and organisational factors both in the selection and interpretation of evidence (Payne, 2004; Munro, 2004b; 2004c; Parton, 2006).

This process will also be influenced by informal or latent functions associated with record keeping within an environment (such as diverting responsibility on to others, avoiding blame, or demonstrating status and authority) which can impede the primary function of investigating possible abuse or risk to children. There are also problems of interpretation when records are shared between people, profession or agency (particularly over time). The meaning of statements to the creator may not be easily conveyed appropriately to others, due to jargon, organisation of the record, or other factors, for example, the lack of accurate information (Garfinkel, 1967; Berger and Luckman, 1967; Russell, 1991; Ricoeur, 1991; Schutz, 1997; Samavor and Porter, 1999).

Consequently, this study focuses on the social constructs of the way child protection issues regarding communication are perceived in everyday life. Therefore, the objective of this research lay in allowing the staff to tell the story as it is (Harris, 1976; Zinman, 1978; Melia, 1982). According to both Melia (1982)

and Michell (1999) telling it as it is involves gaining knowledge of the experiences, perceptions and opinions of the participants. However, a number of other authors have suggested that knowledge is not as simple as it is first seen and they suggest that for many qualitative researchers absolute knowledge of reality is simply not possible, as knowledge of social reality will always be affected by the interpretations of the researcher (Schutz, 1967; Gadamer, 1976; Melia, 1982; Lincoln and Guba, 1985; Patton, 1990; Hammersley, 1992; Davenport and Prusak, 1998).

5.3 Phenomenology

According to Denzin and Lincoln, (2005) phenomenology is a complex system of ideas associated with the work of Heidegger (1962) and Husserl (1970) and is concerned with the lived experience. It has also been argued that although the work of Husserl (1970) was concerned with the world of everyday experiences as expressed in everyday language, he does not limit the objects of phenomenological study to things out-there in the world, but addresses matters of all things that can be objects of consciousness.

5.3.1 *Phenomenology in nursing research*

Discussions of phenomenological research in nursing regularly appeal to either Heidegger (1962) or Husserl (1970) justifying the technical and conceptual resources they deploy. Thus there has been a lot written by nurse researchers about phenomenology as a nursing research technique (Benner, 1984; Owen, 1996; Caelli, 2000; Giorgi, 2000a). However, based on the philosophy of either Heidegger (1962) or Husserl (1970) it appears that nurse researchers are offered significantly different perspectives about the human condition. There appear to be some obvious tensions between what Heidegger (1962) claims the aim of phenomenology is and how Husserl (1970) re-figures that claim, as Heidegger's (1962) philosophical conception offers greater possibilities than the absolute essence, which Husserl (1970) pursues. Nevertheless, the work of Crotty (1996) indicates that the essential differences between these two phenomenological schools have not been adequately documented or evidenced in nursing research**.** He also argues that much of the phenomenological research conducted by nurses cannot be, since their investigations do not espouse the constructionist

epistemological position regarded by Heidegger (1962) or Husserl (1970). Therefore, the question is posed as to whether all such research is accurately identified as belonging to the traditional scientific method.

Paley (2005) argues that nurse researchers largely misunderstand these concepts. Therefore, as a result, their version, which is to be found in nursing literature bears little resemblance to the original focuses of phenomenology, and the traditional phenomenological method and the accounts of it. He indicates that for nurse researchers who cite Heidegger (1962) or Husserl (1970) as an authority, there may be a further consequence. For it may be that the project of identifying the essential structure of a phenomenon, typically adopted by nurse researchers, may come close to being worthless. According to the work of other authors (Crotty, 1996; Giorgi, 2000b; Paley, 2005), while the methods used in phenomenological nursing research may still have some legitimacy, they cannot achieve what they are believed to achieve, therefore they should be separated from ideas and terminology of the traditional phenomenological framework that is supposed to justify them.

However, the phenomenology community in particular psychologists such as Van Kaam (1966), Colazzi (1978) and Giorgi (1985) from the Dusquesne School have made significant contributions to nursing research. This has evolved from their dissatisfaction with the limitation particularly about the errors around the empirical approach, since the critical tests of theory and measures of validity/credibility/reproducibility can be affected, if certain methods are employed inappropriately. Therefore their proposed method which involves description, reduction and the search for essential structures have been credited with the task of establishing reliable methods for conducting phenomenological research.

Literature suggests that in nursing, care is a way of being that must be understood. Therefore for a growing group of nurse researchers the traditional scientific method has become restraining (Denzin, 1984; Benner, 1984; 1990; Benner and Wrubel, 1988; Diekelmann and Tanner, 1989). According to the work of Benner (1984), this method's inherent nature reduces the human being under study to an object of many quantitative units. Consequently, it gives no clue as to how to fit these units back into the vital whole that is the living human being with whom the nurse

interacts in practice. Benner (1984) indicates that as nurses begin to recognize the incongruities between their philosophy of nursing and their research methods, growing acceptance of phenomenology as an alternative research method is occurring. Benner's theory of novice to expert (1984) is an example of phenomenology being used to develop nursing theory. This trend is evidenced by the increase in publications of phenomenological research studies in nursing literature (Benner, 1984; Owen, 1996; Caelli, 2000; Giorgi, 2000a). Additionally, the work of Benner (2001) argues that phenomenological research techniques offer nurses a valuable way to understand the life world of nursing. She infers that a phenomenological approach to studying nursing holds that cultural and social contexts create the conditions of possibility for the nursing experience.

The work of Berger and Luckmann (1967), Schutz (1967), Husserl (1970), Zinman (1978), and Hammersley (1992) imply that there is uncertainty as to whether the world outside of human experience has a real existence. They contend that without people's thoughts, the nature of the outside world can never be known and all that is known is how people perceive and interpret that reality. In this study, an important aspect arising from a phenomenological point of view is the influence of the process of the child's assessment on documentation. For, if the circumstance in each situation is not evaluated appropriately, the correct decisions may be hindered, which inevitably influences record keeping. In other words, the importance of people's interpretation of events and circumstances are emphasised. As a result this research study which sits within an interpretive paradigm (Denzin and Lincoln, 2005) employs a hermeneutic phenomenological epistemology; to investigate how people interpret their lives and make meaning of their experiences (Heidegger,1962; Crabtree and Miller, 1999; Denzin and Lincoln, 2005; Polit and Beck, 2008)

5.4 Other relevant research issues

5.4.1 *The overview of the use of A&E child records*

For the purpose of illustration, it has been estimated that in the United Kingdom there are two million child attendances each year to A&E (Audit Commission and Healthcare Commission, 2007; DCSF, 2009). From a local perspective in 2007 the average number of attendances to A&E was 63 children per day. Also, for further

illustrative purposes, the local A&E department used as the setting for this project designed the format of the records[20]. These records are paper-based, blue in colour[21], only the demographic details are computerised, any other or additional information is not recorded on a computer system.

5.4.2 *Records and child's journey following arrival in A&E*

When a child attends the A&E department, the records as outlined above are used for various stages of the children's investigation and treatment[22]. Therefore, diverse members of the multi-professional team, for example doctors and nurses, enter clinical details in the multi-disciplinary notes manually. At present the details recorded by hand in the multi-disciplinary section are not included electronically as there is no facility for scanning the records. Ambulatory children who present to the A&E department go first to the reception desk where a receptionist enters demographic details directly into the computerised patient record system. Details collected at this stage includes the child's full name, address, post code, date of birth, sex, GP, school attended, presenting problem, date and time of arrival, mode of transport, accompanied by whom, place from where they have arrived.

[20] Outline of records shown in **Appendix 22**

[21] Shown in **Appendix 21**

[22] Both the journey of the child and records are shown in **Figure 5.1** below

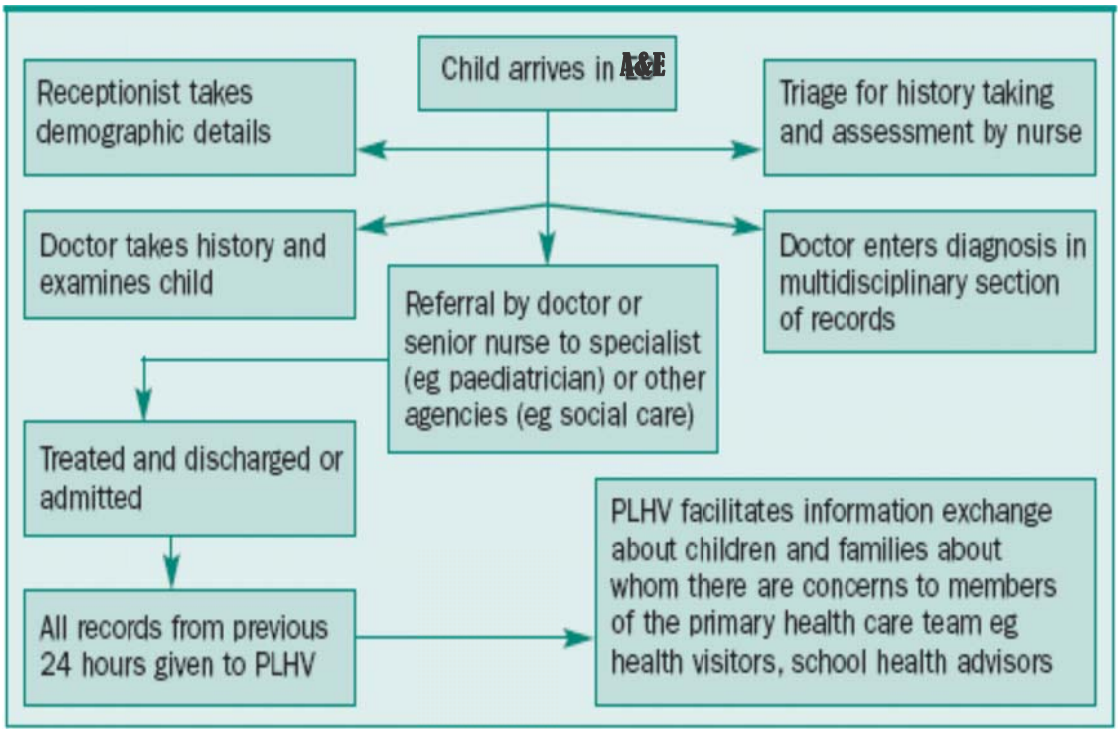


Figure 5.1 Flow chart of the journey of the child and records

The child then proceeds to triage assessment (this assessment is to enable the multi-professional A&E team to treat urgent cases first). Following triage, the child is either asked to return to the waiting area to await treatment or is taken directly to the minor injuries treatment area for examination by a doctor. The child receives the necessary treatment and is then either admitted to hospital or discharged. Children who are not ambulatory are booked in by their parents/carers or ambulance personnel if parents/carers are not present, transferred to an accident and emergency trolley and taken to an examination room for triage and observation. They are then examined by a doctor, who enters a diagnosis and disposal methods into the multi-disciplinary section of the A&E child records at an appropriate point in the child's treatment. The child receives the necessary treatment and is either admitted to hospital or discharged by the doctor. Alternatively a senior nurse can discharge the child using the information recorded by the doctor in the A&E records.

5.4.3 *Integrated Care Records*

Integrated record keeping, an important element associated with this study is an essential aspect of a primary care led health service. (Scottish Home and Health

Department, 1996; Audit Commission, 1997; DH, 2006). The delivery of a cohesive service that improves outcomes for children can only be achieved with good communication and a shared perception of the needs of the child (HM Government, 2006). The need for integrated working to improve outcomes for children is emphasised in Every Child Matters Information Sharing Practitioners Guide (DfES, 2006). It suggests that only when practitioners have a good knowledge base of when, why and how they should share information confidently, and appropriately, as part of their everyday practice, can they hope to succeed in ensuring that children are safe (DfES, 2006). So in order to improve record keeping, enhance communication between professionals and support the expanding primary care teams, a computerised framework for a new generation of integrated records was introduced.

5.4.4 *Computerised framework*

The computerised framework to assess children's needs began in 2004 as part of the Every Child Matters reforms (DfES, 2004a). Since then, there have been significant developments in technologies, such as NHS Care Records (DH, 2004), the Integrated Sharing System and Assessment (DH, 2006) and NHS Connecting for Health (DH, 2007). There has also been progress with implementation programmes in England and Wales, and a shift towards closer integration between clinical practice and medical research.

The development and implementation of the Integrated Children's System (ICS) is concerned with planning, intervention and review, as well as assessment (DSCF, 2008). The ICS was informed by a broader way of thinking, primarily from the work carried out since the launch of the assessment programme and is consistent with the government's Every Child Matters Green Paper (DfES, 2003b). In particular, the ICS was only operable if the implemented recording systems were in an electronic format, thus overcoming conceptual concerns such as professional and technical barriers.

Nevertheless, the Protection of Children in England: A Progress Report (Laming, 2009) indicated that, currently, the technology that supports the use of the ICS is hampering progress. The reason being, that professional practice and judgement are

said to be compromised by an over-complicated, tick box assessment and recording system. For example, concerns about ICS (Laming, 2009) raised in evidence suggest that the systems do not support reflective thinking and risk analysis. Laming (2009) argued that there is no single national IT system that delivers the ICS requirements, for although some areas have access to systems that support practice, there are wide variations.

It is generally recognised that A&E is a clinically challenged and complex department (DH, 1995a; HM Government, 2006; 2010) with distinctions to be made between information sharing, confidentiality, safety, and data protection, nevertheless, locally, child records are paper based and stand alone. Therefore in order to share information with other professionals or agencies, within the hospital or the community, this document is currently photocopied. At the time of writing, August 2011, local Information Technology (IT) systems in the A&E department and services of the Primary Care Trust cannot communicate with each other. There remain fundamental limitations in local systems that impact daily on the working lives of professionals. As a result, the quality of their work in relation to information sharing is likely to be affected (Laming, 2009; National Audit Office, 2011). Therefore, improving care through information sharing remains the principal goal of integrated health records (Laming, 2003; 2009; Balls, 2009; National Audit Office, 2011). Furthermore with regards to the direction of greater accountability, responsibility and governance, this would ultimately depend on how local practice can affect the changes proposed in the Green Paper (DfES, 2003b).

5.4.5 *PLHV involvement*

As a Paediatric Liaison Health Visitor (PLHV), I am a qualified practitioner with a wealth of experience gained over many years from varied sources, which include nursing, midwifery, health visiting, and family planning. A Primary Care Trust (PCT) currently employs me and I am located on the premises of an Acute Hospital Foundation Trust. This is the main district general hospital, which is also an associate teaching hospital. The PLHV's role is not a uniform position in all A&E departments throughout the United Kingdom. The presence of a child-focused liaison practitioner in A&E departments is in itself non-standard practice. Nevertheless, although the role of a PLHV is not a standard role nationally, it has

been recommended by the Laming report (2003; 2009) and the intercollegiate document from the Royal College of Paediatrics and Child Health (1999; 2007).

In spite of the lack of a clear definition for the PLHV's role, which is reflected in the fact that written literature is scarce, personal accounts from other PLHVs suggest they have been employed as far back as the 1970s. There is no specific training available to become a PLHV, the essential requirement being experience in health visiting and, more recently, experience in children's nursing has become acceptable. Presently, most PLHVs are employed by PCTs with a few exceptions who are employed by Acute Hospital Trusts. In some rare cases, they are jointly appointed by PCT and Acute Hospital Trusts.

As a PLHV my main duties are to establish, develop and maintain an effective system of communication between hospital and Primary Health Care Services together with other agencies, in order to enhance the services provided for children. Thus for children attending A&E locally as a result of unintentional or intentional injury, my responsibility as the PLHV is to provide information to other professionals. So I am responsible for the management and collection of relevant and accurate information to assist the Primary Health Care Team in their role of protecting and supporting children. Therefore all the records of children (birth - 16 years) attending A&E in the previous twenty-four hours are made available to me every day. The contents of these records would then be assessed daily by me using the process of reading, reviewing and evaluating. Subsequently relevant and timely information would be communicated to other community professionals (health visitors, school nurses, social care) in order that children could be offered the appropriate support. Although as a PLHV I deal with all members of the primary care team (for example general practitioners, paediatricians, child and family consultation services, therapists, social care, safeguarding children's nurses) I mainly deal with health visitors and school health advisors.

As a clinician, I work in accordance with the Nursing and Midwifery (NMC) Code of Professional Conduct (NMC, 2008). Therefore I work with a view, that in order for practice to be successful, changes that might make practice more efficient are an essential requirement. Although the sharing of information arises from legal

obligations such as the Children Act 2004, I acknowledge its importance in the safeguarding children arena. According to the WTSC document (HM Government, 2010), effective information sharing underpins integrated working and is a vital element of both early intervention and safeguarding. Consequently, effective documentation is the key, for without it effective decisions cannot be made. Equally, inaccurate accounts could lead to children remaining unsafe, or to the possibility of inappropriate actions being taken that affect children. Therefore, as the researcher/PLHV I agree with the WTSC (HM Government, 2010) document that effective information sharing[23] is the key to successful collaborative working and early intervention.

5.5 Research design

Two designs (attitudinal survey, case study) were considered relevant to developing an understanding of how the process of recording keeping and information sharing is undertaken by colleagues in health and social environments. An attitudinal survey of perceptions could have been used to identify professional standpoints, and other variables influencing the creation and sharing of relevant information on children. Whilst this might allow for a larger range of participants and a greater breadth of data, this design makes it difficult to understand or make sense of the symbolic interaction of participants with different roles and responsibilities (Young, 1966; Moser and Kalton, 1971; Blumer, 1986; Cartwright, 1987; Rogers, 1988; Singer and Presser, 1989). It also makes it difficult to exchange negotiated meanings which are undertaken through the process of collective recording and communication of information with others. For those reasons the preferred approach was the case study design.

5.5.1 *Case study design*

The case study approach to research has a long history. Hamel et al. (1993) trace the traditions of the case study to the ethnographer Bronislaw Malinowski's fieldwork in the Tobriand Islands during the early twentieth century (Young, 1979) and to Frederic Le Play (Hamel et al. 1993), founder of French sociological fieldwork and developer of the case study method of inquiry. The case study

[23] The Information sharing practitioners' guide (DfES, 2006, p.5) states: that "*effective information sharing' is accurate, up to date, necessary for the purpose for which it is being shared, shared only with those people who need to see it, and shared securely*".

method became an important tool of sociologists in the Chicago school during the early twentieth century. This form of case study, like Malinowski's, was ethnographic. Problems relating to industrialisation and the influx of immigrants resulted in subsequent urban overcrowding, poverty, illness, and violence. Therefore sociologists adapted case study methods to explore these problems from an impersonal perspective (Hamel, et al. 1993). The work of Crabtree and Miller (1999**)** suggests that case study research offers a real life adventure in one's own practice. They imply that, like an adventure, a case study research project takes the researcher on a journey. They also suggest that this adventure is experienced through mapping the journey, defining goals, and by identifying the field or destination. They contend that, whilst trying to make sense of what is going on out there, it is by engaging in the process of doing the fieldwork that the researcher is enabled to understand their world.

The rationale for choosing case study research as a technique is based on Stake's (1995) account of the art of case study research. Stake (1995) argued that as a form of research, case study is defined by the interest in an individual case, not by the methods of inquiry used. His emphasis is on designing the study to optimise understanding of the case rather than to generalise beyond it. He does not claim that his definition of a case study is generally accepted. He indicates, however, that for a qualitative research community, case study is both the process of inquiry about the case and the product of the inquiry. Stake (1995) argues that one must first identify the goal of the research. He indicates that in a qualitative case study one of the goals is to achieve explanation of a particular situation and that cases are chosen to maximise what we learn. He points out that a case study is defined by interest in and concentration on an individual case. He differentiates between quantitative and qualitative case studies, and contends that a qualitative design is better suited for looking at inter-relationships of variables to understand phenomena within a case. Hence, this framework offers a unified view of objective and subjective realities. Therefore, in this case the complexities of information sharing within and between health and social environments can be described more effectively, and attention can be given to the inter-relationships which influence the records such as the macro, meso and micro picture of safeguarding children (see Chapter 4 and **Figure 5.2** below).

Macro-level	Government's legislations and guidelines.
Meso-level	Practice, team cultures and collaborative relationships with other professionals.
Micro-level	Local/community level, A&E, organisational, and local policies.

Figure 5.2 Illustration of the Macro, meso and micro picture

In addition, a number of authors (Merriam, 1988; Czarniawska, 1998; Yin, 2003; Creswell, 2007) have helped to inform the decision to choose the case study technique. Merriam (1988) provides a rational discussion on the application of case study approaches in the field of education. She provides an informative and valuable approach that was useful to facilitate the study. She does so by illustrating the process for the preparation for a case study, giving information on the method used for the research question, and by describing the case in detail.

The work of Yin (2003) describes the case study approach as an extensive examination of a single instance of a phenomenon of interest. He gives details of some of the earlier applications of case study research and describes some of the basics to engage in the process. Yin (2003) discusses the significance of data collection methods in relation to the project's overall theoretical perspective, and the importance of data collection strategies. He explains the dichotomy between qualitative and quantitative research and dispels the notion that one is built on hard data and the other on soft. As the study relates to concerns within a clinical field, his presentation and interpretation of the approach lends itself to the study in that it can guide and shape understanding of the use of child records.

Creswell's (2007) illustration of multiple perspectives in the comparative survey of five qualitative research traditions provides a range of information that can be used to inform the study. He does this largely by giving full descriptions of the activity that has taken place during the case study. Czarniawska (1998) expresses the role of storytelling in case study research most eloquently, thus presenting a further view that can assist the researcher in understanding and interpreting the meanings that may be beneath the larger story of this study. Therefore, a wealth of valuable information has been provided, which has enhanced understanding and has helped

to explain more about the process, by illustrating different strategies and values of the case study approach. Having reflected on the knowledge gained from the above authors, the conclusion was the case study design was suitable for this study. The research design also indicated that this type of qualitative inquiry would result in rich in-depth information that has the potential to elucidate the multiple dimensions of a complicated phenomenon. Given that this case poses challenges as it involves complex processes and inter-relationships, it is recognised that multiple realities exist for participants and the fact that there is a possibility that this research will change someone else's reality.

5.5.2 *What this case study involves and how phenomenology fits with the case study design.*

According to the work of Stake (1995) a case study explores a phenomenon through within a circumscribed setting or context. Stake (1995) also stresses that the benefits of qualitative case study methodology arise from its emphasis on the uniqueness of the case. This case study involves staff in one A&E and agencies associated with that department and is about how they interpret their lives and make meanings of their experiences. Hence the audit of records was a rich source of data that could be fruitfully exploited to answer the research question, and two focus groups could be used to explore the participants' knowledge and experiences. The purpose of a phenomenological research study is to gain an accurate understanding of another's experience, to capture in depth reflections by participants regarding their experience of an identified phenomenon (Creswell, 2007). Merriam (1988) believes that phenomenology as a school of philosophical thoughts underpins all qualitative research. This study fits into the case study design as it utilises a phenomenological approach to explore the following phenomenon: the use of child records in one hospital's Accident and Emergency Department (A&E) from the perspective of the staff that use these records. Therefore, the case study design fits with phenomenology as it draws on phenomenological concepts and strives to discover the essence of the lived experience. In this case, it is the study of the use of A&E records in one location.

5.6 Sampling

In qualitative research, which normally uses field, documentary or historical research, sampling is not driven by a need to generalise or predict, but rather by a need to create new interpretations. In this field of research, sampling strategies strive for information richness (Patton, 1990). Usually, the investigation wants to increase the scope or range of data to uncover multiple realities and/or create a deeper understanding. This study sought greater understanding of the importance of the human element on documentation. As a result, the theoretical demands of the study as a framework articulated and reflected the choice of sampling. Thus purposive sampling was used as a guide in obtaining data sources that would maximise the richness of the information for this study. This method of sampling was a deliberate non-random method (Stake, 1995; Mays and Pope, 1996).

5.7 Methods

Methods are techniques used to collect evidence about what exists. Since this study was guided by the research design, the process of qualitative methods for data collection was chosen (Babbie, 1973; Creswell, 1994; Denzin and Lincoln, 1998; Creswell and Miller, 2000; Davies and Dodd, 2002; Bryman and Bell, 2007). Therefore data from an audit of A&E records and two focus groups was used for addressing the research question detailed previously[24].

5.7.1 *Data Sources*

The study was carried out in three stages independently (the first stage was considered by the Ethics Research Committee to be an audit).

Stage one - For one 24-hour day a month on different days of each week over a period of six consecutive months (26 weeks) a purposeful sample of records was audited.

Stage two - Focus Group - a purposive sample, 12 members of the local operational child protection group.

[24] Summary illustration of data collection methods is shown in **Appendix 28**

Stage three - Focus Group - a purposive sample, 12 members of A&E staff, the case study site.

5.8 Ethical issues

Ethics is both a subject area and a body of knowledge. It is concerned with the acquisition of moral awareness and the understanding of the rules and principles that allow us to decide individually or collectively that certain actions are right or wrong. It is about personal or public judgement as to what is desirable or undesirable, and what we ought or ought not to do (Polit and Hunger, 1999; Lobiondo-Wood and Harber, 2006; Polit and Beck, 2008). Basic ethical principles relevant to the conduct of research are (a) people have the right to self-determination and to treatment as autonomous agents. Thus they have the freedom to participate or not to participate in research (b) persons are treated in an ethical manner, their decisions are respected, they are protected from harm, and efforts are made to secure their wellbeing and (c) human subjects should be treated fairly (Polit and Hungler, 1999;.Lobiondo-Wood and Harber, 2006; Polit and Beck, 2008).

Researchers are bound by their professional codes of conduct as well as guidance provided by the research in general. Intellectual honesty and integrity are required at each level of the enquiry. Integrity is an ethical stance that causes one to adhere to one's values. The word is derived from integer - a whole number that is broken into fractions. The process that leads to integrity is one of reflecting on and acting in such a way that one's duty to oneself and one's duty to others are brought together in action. Mitchell (1982 p.163) describes it thus; 'Integrity directs attention to the moral agency of the health professional. Integrity is a fundamental moral concept because it intimately involves the concept of self as well as the self in relation to others.' Therefore, issues relating to integrity are addressed not only by the research design which involves a clear focus of the research question, but by using a reflective qualitative case study and by gathering the most appropriate information that will answer the research question (LeCompte, Preissle and Tesch, 1993; Denzin and Lincoln, 2005).

Inherent in all research is the demand for the protection of human subjects (Lobiondo-Wood and Harber, 2006). Consequently, as part of the protection of people's rights and interests the Local Research Ethics Committees exists for the scrutiny of proposed projects. Research with human beings, as in this study, are guided by ethical principles that may sometimes interfere with the researcher's ultimate goal. Thus, it is possible for ethical dilemmas and conflict to arise. For example, the researcher becoming so closely involved with the study participants that they become willing to share secrets and information as they would with a friend. Therefore, it is essential that the researcher ensures that he/she follows the ethical code.

The very nature of the research and the methodology adopted required ethical approval from Essex 2 Research Ethics Committee. Ethical approval was given in 2007 (**Appendix 9).** This project is also an educational project, undertaken in part fulfilment of a PhD. Thus, the University's Research Degrees Committee approved the research proposal in 2007 (**Appendix 1**). In addition, the relevant Research and Governance departments gave approval for registration in 2007. The rationale of the research, the methods adopted and the intended outcomes were explained to all of the participants. For the first stage of the study which was the auditing of records, the documents that were audited were existing samples of A&E records (discussed later in this chapter). For the second and third stages of the study, consent was acquired in writing by the researcher facilitating the focus groups prior to group discussions. Focus group consent forms were sent out with letters of invitation and a participants' information leaflet (**Appendices 3-6**). Participants who were willing to be involved in the focus groups were asked to complete and return consent forms via the internal mail. Participants had access to research personnel at any point to clarify information. All participants who agreed to participate in the study gave their informed voluntary written consent. The process of informed consent was sought and obtained in advance and at all times the rights of the individual, the multi-professional team in A&E and the LOCP group were protected. The other important issue that involved others as well as myself was the issue of collaboration.

5.8.1 *Collaboration*

This is required in all clinical endeavours and is just as important to multi-disciplinary collaboration in research. The Nursing and Midwifery Council's (NMC) code of professional conduct, standards for conduct performance and ethics (NMC, 2008) stresses the importance of working together in a collaborative and cooperative manner with other professionals respecting and recognising their particular contribution. All agreements made between the researcher and the participants, including adherence to the procedures outlined in advance were honoured. The evidence for the second and third parts of this research study came primarily from human participants. Therefore, the need for human co-operation was inevitable. A need for openness and cooperation is a challenging requirement in any research.

5.8.2 *Conflict of interest*

As a practitioner, although I am obligated to advance knowledge by using the best methods available, I must also adhere to the dictates of ethical rules that have been developed to protect human participants. According to Polit and Hungler (1999), nurse researchers involved with human participants are sometimes in a dilemma. This is because the researcher holds trusted relationships which can be compromised by real or perceived conflicts of interest, for actions taken in the course of performing their functions related to the research (Rawls, 2003). In this project, I was confronted with the ethical dilemma of a conflict of interest, a circumstance in which my expected behaviour as a nurse came into conflict with the expected behaviour as a researcher. For although my presence in A&E was only a small part of my working day and there was no familiarity between myself and the A&E staff, it was recognised that this could be perceived as a conflict of interest. Therefore, as the researcher I needed to address conflicts of interest, real or perceived, to maintain confidence and trust in the research. In order to manage the situation ethically and ensure that procedures were fair, provision was made for an impartial person to be present. The impartial person in this case took notes during the focus group discussions, thus duplicating what was being tape recorded. She was a health visitor employed by the PCT, and had recently completed her own research project. She also had prior experience with data collection and was a willing volunteer.

5.8.3 *Impartial person*

This approach is concerned with ethics and follows a broad ethical tradition. The impartial person assumes a position where his or her interests are not at stake and they should possess the requisite information and powers of reasoning in order to be neutral. The impartial person should also be equally sympathetic to the desires and satisfaction of everyone affected by the social system (Firth, 1952; Frankena, 1973; Criswold, 1999; Carson, 2000; Anderson, 2005).

5.8.4 *Confidentiality*

All information that was disclosed during the study was treated with strict confidentiality and was secure at all times, in a locked filing cabinet within the premises on the case study site, in accordance with the Data Protection Act (DH, 1998). The focus group's discussions did not identify participants. However, contributors were aware that if anything disclosed affected the wellbeing of children, or was detrimental to professional practice, I was obliged to inform their line manager, who would investigate and action appropriately in line with Trust policies. However, if participants felt that they had any dissatisfaction during the study, they were aware that they could seek advice from their line manager, another member of the multi-professional team or someone independent, such as a member of the clinical effectiveness unit on the case study site.

5.9 Gaining entry to the research site and informants

Stake (1995) discusses the process of gaining access and permissions to the selected site to ensure cooperation and access to informants. He points out that obtaining written permission from formal authorities to enter the site for the collection of data is essential. This process is said to maximise cooperation and make the entry process as organised as possible (Crabtree and Miller, 1999). In this project, in order to gain entry to the research site and informants, I needed to pass a number of gatekeepers defined by Benton and Cormack (2002) as those individuals who can either facilitate or block access of the researcher conducting the study. I also recognised the fact that it was important to acknowledge that the A&E staff may have felt that having a field worker in their midst was a burden. Nevertheless, it was also just as important to ask for their cooperation. For this

study, I had the full support of all team members in A&E, including managers, nursing and medical staff (see **Appendices 14-19**).

In order to access the children's records I also needed the permission of the Caldicott Guardian[25] of the NHS Hospital Trust (DH, 2008). Although, in the United Kingdom a case record is the property of the Secretary for Health, safe custody is delegated to the Caldicott Guardian, which in this case was the Director of Nursing of the Trust hosting the research. Since the introduction of the National Health Service (NHS) reforms (Department of the NHS Executive, 1999; DH, 2000), the issue of research access has become even more complex in some respects. As a result, managers of NHS Trusts are not only conscious of the need to protect the interest of research subjects who are often vulnerable, but they are also concerned about safeguarding their own careers. For if such research produces adverse findings their position may be compromised if data relating to quality of care is handled in an insensitive way. In the first instance, I had to gain written permission from the people with managerial responsibilities in A&E (see **Appendices 14-19**).

I received written permission from the sub-director for emergency care in January 2006, a copy of which was sent by the sub-director to all A&E consultants, the clinical nurse and service manager. In May 2006, the A&E clinical nurse manager gave permission[26]. At this time, my academic supervisors requested some minor amendments to the study. I wrote again in September 2006 to the sub-director of emergency care with the necessary updates[27] and received written confirmation supporting continuation of the study[28]. In October 2006, I received a letter from the clinical lead/A&E consultant requesting further dialogue concerning the study[29]. An appointment and discussion took place in October 2006, the result being that I received further support. This brought me to the challenge of the

[25] A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.
[26] **Appendix 15**
[27] **Appendix 16**
[28] **Appendix 17**
[29] **Appendix 18**

Research Governance (RG) approval process. My experience as a researcher was, that despite having the required support for the study, I was involved in a long series of negotiations. This was because other documents were required by both the Acute Hospital and the Primary Care Trusts (shown below in **Figures 5.3 and 5.4**). These were in addition to the completion of the RG project application form and provision of the Local Research Ethics Committee (LREC) ethical approval letter.

- A certificate of attendance–Research Training-Good Clinical Practice and Research Governance;
- An honorary contract issued by the Acute Hospital Trust;
- A Criminal Records Bureau (CRB) check (DH 2006);
- PCT supervisor's Curriculum Vitae (CV), specimen signature and signed declaration to say she is willing to be my supervisor;
- Academic supervisors' C.V.;
- A completed risk assessment of the project.

Figure 5.3 Additional documents required by the Acute Hospital Trust.

- Application for extension of study leave and agreement of extension of study leave;
- A letter of support from PCT supervisor;
- Letter of support and continued access from the A&E team of the host organisation;
- Funding confirmation, and costing analysis of the project.

Figure 5.4 Additional documents required by the Primary Care Trust (PCT).

Appleton et al. (2007) suggest that there has been considerable debate about the length of time it can take and the process required in the United Kingdom to gain ethical approval for research. They indicate that, as a result, the National Agency COREC (Central Office for Research Ethics Committees) has begun to implement

measures to improve ethical scrutiny. COREC works on behalf of the Department of Health to co-ordinate the development of operational systems for Research Ethics Committees (RECs) in the National Health Service in England. It is now part of the National Patient Safety Agency. Appleton et al. (2007) described an organisational case study in which challenges and lessons from primary care are outlined with the intention of generating debate around streamlining of the Research Governance procedures. Interestingly this case reflected my situation to some extent in that it involved research by a PLHV, whose role is to assess A&E records daily, but one who is employed by a PCT and not by the NHS Trust hosting the research. Discussions involving complex internal dialogue varied considerably, and to such an extent that decisions threatened to delay the project. Opinions ranged from provision of an honorary contract, my process for complaints or incidents, to the need for a health check before the project could begin.

My experience echoes the case study by Appleton et al. (2007) in that it took some time to receive Research and Development approval (RD) as I struggled with the RG regulatory systems. I felt frustrated with the RG arrangements of both the Acute Hospital Trust and my own PCT as there was no consistency. Decisions made by each Trust differed in detail. In reality, this process proved to be time consuming and complex, particularly at a time when there is considerable restructuring within the NHS. Finally in May 2007, I received confirmation of satisfactory completion of all RD checks.

5.9.1 *Dilemmas of researching in my own practice area*

According to Coghlan and Casey (2001), when insider researchers augment their normal hospital membership role with the research enterprise, the research process can become more difficult and awkward. Therefore in trying to sustain a full organisational membership role and the research perspective simultaneously, nurse researchers are likely to encounter role conflict and find themselves caught in loyalty tugs, behavioural claims and identification dilemmas. This has been challenged by Brannick and Coghlan (2007) who argues that within each of the main streams of research there is no inherent reason why being native is an issue and take the stance that the value of insider research is worth reaffirming.

As a clinician, I am working directly and communicating with all of the A&E multi-professional team on a daily basis. So they seek my opinion on a regular basis if they are unsure, or have concerns pertaining to the safeguarding of children. Therefore, as a result of the way that research is constructed and understood within one's practice, as a practitioner/researcher I could have found my role as a researcher and clinician in conflict (Coghlan and Casey, 2001). Working with different disciplines also requires mutual respect, a common language and the ability to give one another due recognition. It is therefore essential to ensure that there is the required balance for the research principles as well as the wellbeing of the child. Perhaps even harder is the importance of having sufficient confidence and trust to offer criticism. In this research however, I already had an established relationship with the group based on mutual trust and respect, hence there were no apparent difficulties encountered (Brannick and Coghlan, 2007).

In everyday practice when practitioners initiate a research project, the study may also reflect a particular set of values relating to preconceptions of the issues and solutions, therefore in the early stages the first dilemma is the ethical challenge of developing research strategies that are fair and respectful to participants. It is also difficult to anticipate what ethical dilemmas will arise during the course of the study (discussed further in ethical issues). Hence it is important to establish accepted lines of communication before the event, so clear and appropriate action can be instigated promptly (McHaffie, 2002). Therefore in this case there were discussions at team meetings with the A&E multi-professional team (A&E- nurses, doctors, clinical support workers, receptionists, departmental assistants, clinical director, A&E consultants, clinical manager, service manager) so they were all fully informed of the project, and were willing to co-operate and offered their support. As a result, my dual role as a practitioner/researcher enabled me to explain the rationale for my project at different levels of hierarchy within the organisational structure, and to obtain sponsorship for my PhD study.

The interconnectedness of pre-understanding, role duality and organisational politics becomes evident in the process of framing and selecting a research project, therefore researching in one's own area of practice also raises questions that require

special consideration (Argyris et al. 1985; Buchanan and Boddy, 1992). Nevertheless, although this research study had the potential to bring reflective practice and emancipatory action together in a way that may have challenged the status quo (Hart 1996, p.459), as a practitioner researcher I had the pre understanding of the hospital's power structures and politics and was able to work in ways that was in keeping with the political conditions without compromising the project or my career (Brannick and Coghlan, 2007).

My role and insights about the situation and the people involved (Brannick and Coghlan, 2007) also assisted me in the design of the study, investigation and analysis of the data, and enabled me to seek support from the clinical audit department, where I had several discussions with the clinical audit facilitators who offered me the benefit of their expertise, and ensured that the data I collected was appropriate and did not contravene the Data Protection Act (DH, 1998). I was also able to negotiate with the organisation, a time allowance to carry out the enquiry, clerical support for the transcribing of tape recordings, analysis of data and writing of the report. Throughout the project I had to maintain the ethical principles, my credibility as an effective driver of change and as a political player with good judgement. As a result implementation problems were minimised.

5.10 Stage one (audit of records)

Although both Elder et al. (2005), and Lobindo-Wood and Harber (2006), have indicated that the use of records, and available data, are sometimes considered primarily the province of historical research, other authors in the field have argued that sometimes existing information can be examined in a new way to study a problem (Kozier et al., 2008; Polit and Beck, 2008; Potter and Perry, 2009). Subsequently, hospital records, care plans, and existing data sources such as the census, are all used frequently for collecting information relevant to answering a research question (Elder et al. 2005; Lobindo-Wood and Harber, 2006; Schneider et al. 2007; Kozier et al. 2008; Polit and Beck, 2008, Potter and Perry, 2009). Thus, as the researcher, I considered that using information that is in the current records might assist in identifying factors that places children at risk. Therefore, a sample of A&E child records was audited in this project, given that the available data in the records was believed to constitute a rich source of information.

Furthermore, information collected from existing hospital A&E records was used to provide evidence to answer the research question. It has been argued by authors in the field, (Kozier et al. 2008; Polit and Beck, 2008; Potter and Perry, 2009) that using available data has certain advantages, because the data collection step for research often is the most difficult and time-consuming. Their work has also suggested that there are other issues that need to be considered. For example, authenticity of the records is relevant, because this relates to the distinction of primary and secondary sources. Hence, in this study the records used are genuine samples which allowed for a significant saving of time. In addition, according to the work of Schneider et al. (2007), Kozier et al. (2008), Polit and Beck (2008), Potter and Perry (2009), by using the data from original records, the problems of reactivity and response set bias is reduced.

5.10.1 *Critique of the use of records as a data source*

Using records as a data source may be challenging for a variety of reasons. There may be issues of consistency as input could come from multiple contributors (such as several professionals); distortions are likely to occur because of differences in professional language and cultures (Russell, 1991). Consequently records could vary through professional choice of words, as a result different meanings and diverse interpretations may be given. Based on Berger and Luckmann (1991), it is recognised that instead of one reality, multiple realities exists. Therefore, in order to acknowledge the complexity and multiple realities of A&E child records; understand and interpret the meaning that they have for the participants and develop a holistic picture, a framework provided by the work of Berger and Luckmann (1991) was utilised. This approach was employed because the social constructed meaning placed on hospital documentation was the focus of the study. Berger and Luckmann (1991), claim that language enhances the individual's ability to identify the important context of symbolic reality and to distinguish the different sources that are the constituents of multiple realities in order to integrate them into a meaningful whole. Berger and Luckmann (1991, p.35-36) described it thus "the language used in everyday life continuously provides me with the necessary objectifications and posits the order within which these make sense and within which everyday life has meaning for me". Therefore the framework they provided

offered a unifying view of multiple realities, enabling me to logically understand and interpret the meaning that the records have for the participants within a natural setting, as a result my interpretation of the data is a consistent factor in the analysis.

Gaining access to records may be difficult and they may also be problematic to retrieve (DH, 2000; 2008). For the reason that the researcher has not been responsible for the collection and recording of information, data may be of questionable accuracy and reliability, as he or she may be unaware of the limitations, biases, or incompleteness of records. The researcher's interpretation of the records may be different from that of the author. Data may be in a different format than is required by the researcher. In terms of authenticity, authorship or accuracy of a task may be difficult if records are old as they may not reflect the current situation (see 5.18.12 evidence from records). Ethical issues regarding confidentiality may arise by gaining access to records that contain personal data (refer to 5.8 ethical issues). These considerations suggest that although existing records may be plentiful, inexpensive, and accessible, they should not be used without paying attention to potential problems and weaknesses (Polit and Beck, 2008).

Although the situation relating to the issues above could exist, in this case because of my role as a PLHV (discussed in Chapter 5 - 5.4.5) these concerns did not arise. Nonetheless, institutions such as hospitals are sometimes reluctant to allow researchers access to their records, in this case the managers of the A&E department were happy for the original records to be used. However, the main area of concern during the audit of the records was confidentiality. Thus, all information and data used to establish findings within the audit had to be anonymised. Because unidentified record based data was used, the Patient Advisory Liaison Service and Caldicott Guardian were actively involved to ensure that procedures were carried out appropriately (reliability discussed in Chapter 5 – 5.6.12).

5.10.2 *Details in records required for this stage of the study*

Standard 5 of the National Service Framework for Children (DH and DfES, 2004b) and the Trust's record-keeping policy (2004)[30] provided criteria for analysing the records. Standard 5 of the NSF (DH and DfES, 2004b) states that as a matter of good practice, staff at all levels need to understand their roles and responsibilities relating to the safeguarding of children and young people and the promotion of their welfare. It also states that they should be trained appropriately to undertake these responsibilities effectively. Therefore, good, safe professional practice requires referrals to be made by the healthcare professional who has examined the child. Appropriate referrals can then be based on medical and non-medical indications. For example, distress, demeanour, family and any other indications which cannot usually be made accurately after the event. This is in line with the Every Child Matters document (DfES, 2004a), and the Laming's (2003; 2009) recommendations. From a safeguarding viewpoint, the standards referred to above are crucial, but in this study, they are also used to demonstrate whether a cause for concern[31] has been identified within the record by staff in A&E. An explanation is given below of why these details used in the audit were pertinent.

The use of demographic variables affect childhood wellbeing at the micro-level, mainly through household and family factors, and at the macro-level especially through the pace of economic growth and the extent of public investment in services and infrastructure of relevance to children (Serra, 2004).

The child's full name and date of birth relates to the needs of the child as it helps in identifying multiple attendances to an A&E department (Laming, 2003). Age is required to assist in preventative practice so that support is provided in response to their needs. The aim is to deliver intervention and multi-agency services that are more effective at an early stage to prevent problems escalating and to increase the chances of a child or young person achieving positive outcomes (DfES, 2004a).

[30] **Appendix 23**

[31] The term cause for concern refers to the records of any child who attended A&E and needed support from services such as health visitors, school health advisors and social care (HM Government, 2010, 2006).

The sex of each child is required as this gives a fuller description of the child (Laming, 2003).

The first three digits of the postcode are required for a number of reasons. Firstly, when practitioners such as health visitors and school health advisors are working with families, they need to be sensitive to indicators of the child's situation that suggest where the child is socially: therefore it helps to show from where the attendee comes. Secondly, it is important for the sharing of information within geographical working areas as it helps to identify the correct practitioners to whom referrals are made. The date and time data are routinely collected to help professionals observe trends in waiting times in order to comply with the government's A&E targets.

5.10.3 *Data on ethnicity*

Section 22 (5) (c) of the Children Act 1989 requires that when making decisions in respect of a child, consideration is given to the child's religious persuasion, racial origin and cultural linguistic background. Information on a child's ethnicity allows for a fuller description of the child, so that, as with age and sex data, it may help, alert the practitioner to specific needs.

5.10.4 *Other relevant information*

The number of previous attendances should be closely monitored. Date and time of incident/accident should be recorded to enable the monitoring of issues such as late presentation of an injury. Any delay in presenting could be a failure to meet the child's needs (Laming, 2003; DfES, 2004a; HM, Government, 2006). In some cases it may be that parents are not accessing General Practitioner's services appropriately and in others the reasons could range from lack of knowledge to neglect. Whatever the reason for the delay, an accurate assessment of the child's needs may not be possible if the information on the date and time of the incident is not recorded in the first place (Laming, 2003; DfES, 2004a; HM, Government, 2006). If the records are illegible or incomplete, this increases difficulties for the PLHV, and subsequently for the professional or agency to which the case is referred. For example, if a fully documented history of a child is not recorded this is likely to affect a thorough assessment of the child (DH et al. 2000).

5.10.5 *Other background information*

Information, such as date and time of incident, date and time of arrival, accompanied by, next of kin relationship factors is needed for identifying the needs of the child, risk of neglect or poor care. These details are noted as possible indicators of inadequate parenting, irregular attendance at school or for not receiving early years services. The same attention should be given to these factors as to those related more directly to the child and parent (DH et al. 2000), and the mode of transport relates to service provision.

Other requirements are that records identify any cause for concern, they are complete, and the history is legible. The Essence of Care document for Record Keeping Bench Marks of Good Practice (DH, 2003) indicates that failure to keep good and accurate records of treatment and advice to patients causes considerable difficulties for the clinician if called upon to justify his or her actions, or to give evidence in legal proceedings. Thus it is possible for professional sanctions to be imposed upon the clinician for poor record keeping. Consequently good record keeping is essential in the context of information sharing, for in the Clinician's Guide - under the heading of Good Medical Practice - providing medical care, the Royal College of Physicians states:

"In providing good clinical care, doctors must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed" (RCP, 2008, paragraph 3, page 6).

Record keeping guidance for Nurses and Midwives booklet, the Nursing and Midwifery Council states:

"Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow"(NMC, 2009, page 1).

The NSF for Children (DH and DfES, 2004b) stipulates that, in order to safeguard children, information needs to be brought together from a number of different sources and careful judgements made on the basis of this information. It further states that well-kept records provide the essential underpinning to good child protection practice. In addition, the Laming report states:

"*When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf*" (Laming, 2003, Recommendation 68, paragraphs 9.72 and 10.30).

5.11 Preparation for the audit

On 30 March 2007, the study was registered with the Acute Hospital, and the local Primary Care Trust (PCT) clinical audit departments. Decisions were then made regarding data collection so, in order to obtain high quality data, an important consideration relating to the required instrument needed to be addressed. Based on the point that there was no existing tool suitable for all the research variables, as the researcher, I was faced with developing an appropriate instrument or tool. First, a schedule for the analysis of the records needed to be created[32], once this was dealt with, attention was then given to the data collection tool.

A	Month	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
B	Date	1st	6th	12th	17th	22nd	28th	5th	
C	Day	Tues	Wed.	Thurs.	Fri.	Sat.	Sun.	Mon.	
D	No of records	63	63	63	63	63	63	63	
E	Gathering Process	DX	DX	DX	DX	DX	DX	DX	
F	Describing	F	F	F	F	F	F	F	
G	Reflection	G	G	G	G	G	G	G	
H	Organising	H	H	H	H	H	H	H	
I	Documentation							I	I

A		Month data gathering commences
B		Date analysis takes place
C		Day analysis takes place
D		No of records to be analysed each day
E		Day of the week data gathering takes place
F		Describing process – on going
G		Reflective process – on going
H		Organising – on going
I		Documentation
X	Indicates - CAS (Critical Analysis Statement) In one 24-hour day a month if I have not seen 63 child records- identify root cause and take remedial action.	

Table 5.1 Schedule for the analysis of records May 2007-November 2007

[32] Shown in **Table 5.1**

5.11.1 *The data collection tool*

A checklist was used for auditing the records[33] as this reflects the most effective strategy for providing the best evidence of input, use, and output. The use of a check list is important, as this type of framework encourages thick description and rich field notes (Spradley, 1980; Bogdan and Biklen, 1982; Stake, 2005; Lobiondo-Wood and Harber, 2006).

Following consultation with the academic supervisors, it was felt that a level of support was necessary. Several discussions were held with the clinical audit facilitators and it was agreed that they would assist with the design. They also offered me the researcher the benefit of their expertise to ensure that only the necessary data was collected and it did not contravene the Data Protection Act (DH, 1998). A data collection checklist[34] was then devised and validation checks were carried out as stipulated by the clinical audit process, in order to ensure that the checklist was tested robustly (Sale, 2000).

The pilot study was a small scale version of the main study and it was useful to test all procedures and the feasibility of the study (Cormack, 2002). The data collection device should result in the collection of data that meets the purpose as intended, is non-ambiguous and straight forward to use (Cormack, 2002). Therefore, all aspects of the data collection tool for the audit were piloted to ensure that the data collected was accurate, reliable, ethical and valid (Sale, 2000). Accordingly, in March 2007, in preparation for the audit of the records a pilot study of the data collection checklist was conducted in the A&E department of another County Hospital by a PLHV. Once the data from the test run was collected and scrutinised, only minor amendments were required. The revisions and refinements, which in my judgement would eliminate or reduce problems encountered during the pilot study, were made. Description is given of how the data was actually obtained in the data collection section located later in this chapter.

[33] Shown in **Appendix 10**
[34] Shown in **Appendix 10**

5.12 Stages two and three of the study (focus group discussions)

The use of focus groups has a more than 40 year old history in social science literature, and originated in the field of marketing research (Stewart and Shamdasani, 1990), but focus groups have been successfully adapted to primary care research (Morgan, 1993; 1998; 1998a; 1998b). After reading Morgan's work, it was felt that the focus group method of data collection was not only an effective strategy for addressing the research question, it was useful for generating rich and diverse views, opinions, and experiences, from the perspective of the staff that use the records. It provides a useful participatory element to the methodology. It was also considered respectful and not condescending to participants (Morgan, 1998; 1998a; 1998b; 1993).

A focus group is a form of group interview that capitalises on communication between research participants in order to generate data. Therefore, the purpose is to explicitly use group interaction as part of the method (Morgan, 1993; Kitzinger, 1994b; Mays and Pope, 1996; Kruger, 1997; Madriz, 2000). A number of other authors (Morgan, 1993; Kitzinger, 1994b; Mays and Pope, 1996; Kruger, 1997) suggest that by creating and sustaining an atmosphere that promotes meaningful interaction, focus groups convey a human sensitivity, and a willingness to listen without being defensive. They also argue that interactions in focus group discussions can provide an explicit basis for exploring issues that may supplement and enrich the research findings (Morgan, 1993; Kruger, 1997).

Determining the difference between the focus group technique, individual interviews and other types of group interviews is essential to the research enterprise (Morgan, 1993; Kruger, 1997; Bloor et al. 2001; Morgan, 2002). The technique of using group interviews is different as it employs a technique in which several participants in a social context can be interviewed simultaneously. One important difference is that in the case of using individuals only the sole story of one participant is captured, whereas a focus group, interactive exchange, produces multiple stories and diverse experiences among the participants (Salant and Dillman, 1994; Mays and Pope, 1996; Morgan, 1998a; Crabtree and Miller, 1999).

Group work also helps researchers tap into the many different forms of communication that people use in day-to-day interaction (Kitzinger, 1994b; Mays and Pope, 1996; Bloor et al. 2001; Duggleby, 2005). For example, jokes, anecdotes, teasing and arguing. Gaining access to such a variety of communication was useful for this project, because the research participants' knowledge and attitudes are not entirely encapsulated in direct questions or in their reasoned responses. It has also been suggested that everyday forms of communication may tell us as much, if not more, about what people know or experience (Kruger, 1994; Mays and Pope, 1996; Madriz, 2000). In this sense, focus groups reach the parts that other methods cannot attain; revealing dimensions of understanding that often remain untapped by more conventional data collection techniques (Kitzinger, 1994b; Mays and Pope, 1996; Kruger, 1997; Crabtree and Miller, 1999; Bloor et al. 2001).

For this study tapping into such interpersonal communication is particularly important because it highlights other professionals' values. Through analysing the operation of humour, consensus and dissent and examining different types of narrative within the group the researcher can identify shared and common knowledge. This makes focus groups' data particularly sensitive to multi-professional variables (Hughes and Dumont, 1993; Kitzinger, 1994b; Mays and Pope, 1996; Bloor et al. 2001; Duggleby, 2005).

The goal in this project was to learn more about participants' personal experience of the purpose and use of child records. Therefore the focus group method was considered useful for exploring the participants' knowledge and experiences, not only what they thought of the records, but how they thought and why they thought that way. This process assisted the participants in exploring and clarifying their views in the ways that would be less accessible in one to one interviews. The approach also allowed me as a researcher to select key informants with access to important sources of knowledge concerning the use of child records (Morgan, 1995).

The down-side, of focus group dynamics is that the articulation of group norms may silence individual voices of dissent. In this project a wide range of

professionals were involved. For example, nurses, doctors, health visitors, school health advisors. Because they differed in the nature and extent of their involvement of the use of the records, the focus group study was conducted in a non-threatening environment, allowing peers to express their perspective, whilst having the security of being among others who share many of their feelings and experiences. However, it was evident that hierarchy and power relationships amongst some group members did have some effect on the focus groups' discussions (see Chapters 6 and 7). In addition, there were also added issues of professional language, historical traditions, belief systems and ethical values. Therefore, to facilitate participants during the focus group discussions, a topic guide[35] was used as a prompt.

'Can you tell me your views on the use of A&E child record as a means of safeguarding children?'

Prompts

- Bring out the experiences they have had when using the records.
- Reasons for using child records.
- Knowledge about the use of these records.
- Do you feel there are issues or concerns that require further discussion or have not yet been addressed?

Closure – explain what happens now.

Thank you.

Figure 5.5 Topic guide for focus groups' discussions

This is a strategy used in focus group discussions to facilitate the process (Salant and Dillman, 1994; Mays and Pope, 1996). By using this scheme, whilst discussing and interacting with each other, participants were encouraged to concentrate on one another rather than on the facilitator (Morgan, 1993; Salant and Dillman, 1994;

[35] Shown in **Figure 5.5** below

Mays and Pope, 1996; Kruger, 1997). In this study group dynamics worked well as the participants work alongside the researcher, taking the research in new and often unexpected directions.

There does not appear to be a consensus on the maximum number of focus groups that can constitute a study. The work of both Crabtree and Miller (1999) and Bloor et al. (2001) inferred that the central decision is determined by the fundamental principle of how many focus groups are required to reach saturation. This is when the topic is adequately covered and additional information no longer generates understanding. However, both the work of Morgan (1995; 1993) and Bloor et al. (2001) implied that the absolute number of focus group discussions feasible in a single study design will always be small and based on their suitability. Therefore, for this project selecting the number of groups was based on the purpose of the study. As a result there were two groups, (a) non-A&E staff who were members of the Local Operational Child Protection (LOCP) group since they were recipients of part of the A&E records, and (b) staff working in A&E given that they provided the records.

5.13 Participants - two local populations were used

- (a) LOCP group list accessed through the chairperson.
- (b) A&E staff were identified by using the duty rota on the case study site.

The focus group study consisted of 24 participants divided into two groups of 12.

A normal focus group will involve six to twelve participants which represents the optimum number (Crabtree and Miller, 1999; Polit and Hungler, 1999; Bloor et al. 2001; Polit and Beck, 2008). A focus group should be about five participants when the topic is sensitive (Cote-Arsenault and Morrison-Beedy, 1999).

Selecting the participants for the focus groups required several considerations such as: the types of individual being recruited; the nature of the group composition; homogeneous versus heterogeneous; the degree of familiarity among participants, and the level of compatibility (Morgan, 1995; Kitzinger, and Barbour, 1998; Bloor

et al. 2001; Crabtree and Miller, 1999). The choice of whether a focus group should be composed of homogenous or heterogeneous participants is still being debated (Barbour, 1995; Bloor et al. 2001; Crabtree and Miller, 1999). Crabtree and Miller (1999) suggest that the decision regarding group composition should be based on the research question, and that homogeneous groups share a common background or experience.

A heterogeneous group can bring together a more diverse set of participants, whose different experiences and points of view can stimulate and enrich the discussion, but with this diversity comes the risk of power imbalances and lack of respect for differing opinions (Kitzinger, 1994b; Michell and Amos, 1997; Michell, 1999; Crabtree and Miller, 1999). Therefore, in making the decision of the use of homogeneous versus heterogeneous these issues were taken into consideration. In this case, if a heterogeneous group was chosen there was a possibility that participants may have introduced new ideas and potentially conflicting perspectives, thus inspiring other group members to consider the topic of the purpose of the use of the records in a different light.

Historically, it was considered best to have groups that were composed of those who were strangers to each other, to prevent preset assumptions, limit group thinking, and preserve confidentiality (Kitzinger, 1994b; Morgan, 1998b). However, this is not possible in all situations. For example, in the case of this study it was not possible or feasible to generate a sample of strangers; nevertheless, it is recognised that group dynamics change when the participants have a prior relationship group (Morgan, 1998b; Stewart and Shamdasani, 1990).

Participants were identified who possessed characteristics or lived in circumstances relevant to the purpose of the use of child records. Therefore it was advantageous to bring together a diverse group of participants from a range of grades and disciplines. For that reason homogeneity of participants was more appropriate. This was intended to capitalise on people's shared experiences, in order to maximise the exploration of different perspectives within the group setting.

All 30 members of the LOCP group were accessed through the chairperson and were sent an invitation letter and information leaflet. There was no way of ensuring that all members of the LOCP were represented, since the only approach that could be used to access them was through the chairperson. From the 30 approached those members who agreed to participate 12 were purposely chosen on the basis that they were specifically identified as they possessed the lived experience relevant to the use of child records (see also previous page). For A&E, in order to ensure that adequate numbers attended the focus group, 12 members were purposely selected from the duty rota within each occupational group and were sent a leaflet and invited by letter to participate. All letters of invitation were sent via the internal mail. Everyone who was approached agreed to participate. However, there was a contingency arrangement if the initial plan did not recruit the desirable sample size. It involved approaching other participants who met the needs of the research and choosing more.

It was considered that the participants' perspectives would be achieved through discussion, asking questions, exchanging anecdotes, and commenting on each other's experiences and points of view. Therefore, the intention was to set up and conduct the focus group discussions in a non-threatening environment; thus allowing peers to express their perspectives, whilst having the security of being amongst others who share many of their feelings and experiences.

There was little control regarding the seating arrangements because the focus group discussions were to be held within a healthcare setting (discussed in data collection section).

5.14 Composition of focus groups

A purposive sample of 12 non A&E participants (group A), representative from outside agencies (**Table 5.2**) was drawn from 30 members of the LOCP group, since they received information from the records. All members of this group were women. The focus group for the LOCP members was arranged following negotiation through the chairperson, to take place during a working day, date and time convenient to members. A purposive sample of 12 A&E staff (group B) (**Table 5.3**) from the case study site was selected from 120 members on the A&E

staff rota. Members of this group consisted of 8 women and 4 men. For practical reasons, the focus group was arranged, following negotiation with the A&E managers, for early morning, taking shift patterns into consideration.

Participants	Number
Senior nurse with supervisory duties (SN)	1
Health visitor with additional nursing skills (HVP)	1
Senior nurse with both managerial and supervisory responsibilities (TL)	1
Senior nurse with additional nursing skills specialising in school nursing (SN1) Senior nurse specialising in school nursing (SN2)	1 1
Safeguarding Doctor/General Practitioner (SD)	1
Assistant with clerical duties (CSW)	1
Senior nurse mental health unit with managerial responsibilities (MHN)	1
Management from social services (SC)	1
Community practitioner specialising in child health (HV1) Community practitioner specialising in child health (HV2)	1 1
Community practitioner specialising in child health with additional nursing skills (HVC)	1

Table 5.2 Participants of the LOCP group

Participants	Number
Paediatrician - medical specialist concerned with the diagnosis, treatment and overall care of children (SD)	1
Senior nurse with managerial responsibilities for children (SN)	1
Senior nurse both managerial and supervisory responsibilities (NM)	1
Senior nursing roles and are involved in direct care of children (SGN1)	1
Senior nursing roles and are involved in direct care of children (SGN2)	1
Tasks are delegated to them by senior nurses who are involved in direct care of children (JN1)	2
Tasks are delegated to them by senior nurses who are involved in direct care of children (JN2)	2
Departmental tasks are delegated by senior colleagues (CSW)	1
Departmental tasks are delegated by senior colleagues (DA)	1
Departmental tasks are delegated by senior colleagues (RS)	1

Table 5.3 Participants from A&E

5.15 Observational data

Observation of human behaviour is a much used technique that involves systematically watching and recording behaviour and characteristics of living beings (Robson, 1993; Crabtree and Miller, 1999) in this case participants from two focus groups. Observation can be undertaken in different ways. (1) Non-participant observation - the observer watches the situation, openly or concealed, but does not participate. (2) Participant observation - this is when someone who takes part in the activity, but whose status as a researcher is known to the

participants (Gold, 1958). Observation can provide rich qualitative data, sometimes described as thick description because by its very nature, lends itself to this type of research since, by definition, it involves experiencing the behaviour you are studying (Robson, 1993; Crabtree and Miller, 1999).

In this study it was important to take into account unstructured observation, for example, behaviours, body language, gestures and eye contact in order to consider all aspects of the use of A&E records (Lofland, 1971; Robson, 1993; Crabtree and Miller, 1999; Pontin, 2002). Unstructured observation is the unplanned, informal, watching and recording of behaviours as they occur in a natural environment, it is a research technique in which the characteristics that will be observed are not predetermined; therefore the researcher would not approach the observation with pre-determined categories or questions in mind. The work of both Lofland (1971) and Pontin (2002), claim that in overt research, it can be appropriate for a researcher to record events as they happen where the people in the research setting know the research is taking place. Therefore in this case as the researcher already had links with the group and the participants were fully cognisant with the research, the use of unstructured observation was considered appropriate (Lofland, 1971; Pontin, 2002).

As the PLHV who was also the researcher, I attained graduate level research training and facilitated the research project. I also have observational skills in my practice and was trained in good clinical practice and research governance (research training certificate of attendance shown in **Appendix 2**). By the very nature of the project, as the researcher/facilitator I was not trying to predict or guess the motivation of participants, thus, using techniques suggested by both Robson (1993) and Crabtree and Miller (1999), unstructured observation was the strategy employed.

Therefore, as the researcher/facilitator I used a note book and pen and details of what was seen as key components of the observed interactions were jotted down. For example, behaviours, body language, gestures and eye contact were taken into account (see Chapter 6). This information was complementary to the focus groups discussions and was used to enhance interpretability, as it represented a very

important source of available data and served to identify areas where difficulties exist in the recording, extracting and sharing of information in a health and social environment. Thus, adding a rich output of data which stemmed from the experiences and perception of the participants themselves. Inevitability, the notes that were jotted down were selective (Robson, 1993; Crabtree and Miller, 1999).

Nevertheless, because these summaries could add subjectivity to the data, it is possible that observer bias may have distorted the information, but the following day I had endeavored to minimise bias by reflecting back on what was heard and seen from the focus groups discussions, in order to better understand what was happening and to move to a deeper level. By making notes of specific details of that which might normally be taken for granted, showed how meanings may have been constructed in this particular setting (Crabtree and Miller, 1999). It is also likely that my presence may have influenced the situation. Nonetheless, according to the work of both Lofland (1971) and Pontin (2002) the fact that the presence of a researcher may change the settings being researched need not be a problem, for it is possible to reduce people's reactivity if there is pre-existing relationship of trust between the researcher and the participants. In this project a relationship between myself and the participants within the group were already established (see also 5.16.4 reducing bias).

5.15.1 *Stages two and three non-verbal communication from non A&E and A&E staff*

Given that this study concentrates on the importance of the human element, it was also relevant to learn more about the non-verbal communication from the focus group discussions as this had an impact on the quality of relationships. According to both Salwen and Stacks (1996) and Polit and Beck (2010), people communicate their fears, needs and emotions in many ways other than just words. Therefore, body language expresses emotions, feelings and attitudes, sometimes even contradicting the messages conveyed by spoken language. In this study it was important to consider non-verbal communication in order to establish the level of absence or presence of interaction between participants of the focus groups within a particular setting. Therefore the aim of the non-verbal communication was only to identify the meaning in which the behaviour and events occurred and is not

concerned with quantifying the duration or frequency of such phenomena. For that reason, the types of non-verbal communicative behaviour obviously needed to correspond with the everyday life perspective.

5.16 Validity and reliability

Within the context of health service studies, qualitative research has sometimes been seen as a soft approach, lacking scientific rigour (Mays and Pope, 1996; 2006). However, there is a second position in which qualitative research can maintain rigour in terms of reliability and validity (Bryman, 2008). Bryman (2008) states that the seminal work of Lincoln and Guba (1985) fits this criterion and a number of other authors (Polgar and Thomas, 2008; Polit and Beck, 2010; Lobiondo-Wood and Harber, 2010) also support this position. Guba and Lincoln (1985) argue that human behaviour relates to context and that the value of data depends on trustworthiness that will convince the readers that the findings are noteworthy. The proposed Lincoln and Guba (1985) criteria for judging scientific rigour in qualitative research for trustworthiness are credibility, transferability, dependability and confirmability.

5.16.1 *Validity*

Credibility of an inquiry involves carrying out the investigations in such a way that the research is believable. My credibility is, in part, due to prolonged engagement in the field, in so doing I have developed an in-depth understanding of the phenomena being researched (Lincoln and Guba, 1985). For the duration of my many years of employment as a PLHV, I have worked as a member of the A&E multi-professional team, and have been involved with this project since December 2005. In addition, internal validity can be established by participants checking credibility of data collected (Lincoln and Guba, 1985). Feedback was provided to the study participants regarding the data and the emerging findings and interpretations. This was achieved by making both formal and informal presentations. Formally at A&E and LOCP group meetings, and informally as an on-going process, allowing for the data to be internally validated. The participants of the research offered positive comments and support for the study. Another aspect of credibility is the faith that can be put in the researcher as the data-collecting instrument (Guba and Lincoln, 1985; Patton, 1990). This is more

relevant to methods such as questionnaires, but consistent application of methods used also applies to this research (discussed earlier).

5.16.2 *Reliability*

Reliability is also related to dependability on the accuracy of data in terms of stability and repeatability. Transferability refers to both external validity and reliability; the extent to which the findings from the data can be replicated by the same research with other groups or settings. It is difficult to justify transferability in qualitative data from a case study, but some data patterns indicated in this study are replicated in the findings from the two Laming enquiries (2003; 2009) which suggest that A&E social environments have similar patterns of responses to child risk evaluations. This is in terms of obtaining an in-depth and holistic understanding of the purpose and use of child records. Since a clear transparent account aids replication, the sampling strategies strive for information richness, and a rich and thorough description of the research, together with the design and process used so that the value of the evidence can be assessed by others. Using thick descriptions to convey findings also enhances transferability, because it increases understanding (Guba and Lincoln, 1985; Patton, 1990).

5.16.3 *Transparency*

A qualitative researcher is required to remain true to the data and acknowledge any personal bias, interpreting findings in a way that accurately reflects the participants' reality, report all decisions involved in ensuring that the data is accurately recorded and the data obtained are representative of the data as a whole. An auditing approach was adopted in order to ensure that completed records are kept of all stages of the research process, such as problem formulation, selection of research participants, fieldwork notes, transcripts from the focus groups, audit of records and data analysis decisions (Guba and Lincoln, 1985).

Worker knowledge is considered to be legitimate as practitioners' research tends to distort reality less often than expert research (Guba and Lincoln, 1994). This is because the practitioner is intuitively closer to the purposes of everyday concerns and interests. As the PLHV I needed to play an active role in leading the project. Therefore, it was necessary to participate and negotiate with the teams in A&E,

providing information and direction in decision-making when asked to do so by the team. Collaborating and working in partnership were the underpinning concepts. I worked in collaboration with the immediate stakeholders (safeguarding children team and A&E clinical director, clinical and service managers, lead nurse paediatrics and head of children's nursing) to whom the research question made clinical sense[36]; therefore, a true account as it was useful for guiding practice (Lobiondo-Wood and Harber, 2006). Moreover, the issues of documentation and information are now being addressed at strategic levels.

5.16.4 *Reducing bias*

Guba and Lincoln (1985) argue that the potential threats to the validity of flexible design research are divided into three broad headings of reactivity, respondent biases and researcher biases.

(a) Reactivity is the way in which my presence as a researcher in some way interferes with the setting which forms the focus of the study and in particular with the behaviour of the participants, as I may unintentionally communicate my expectations to the contributors therefore inducing bias.

(b) Respondent bias can take various forms ranging from hindering to withholding information, or they can distort their behaviour consciously or sub-consciously in order to present themselves in the best possible light.

(c) Researcher bias refers to what I bring as a researcher to the situation. This is in terms of my assumptions and my preconceptions that may affect the way in which the participants behave in the research setting in terms of the questions asked and the selection of data reporting and analysis (Guba and Lincoln, 1985; Crotty, 1998; Padgett, 1998; Robson, 2005; Polit and Beck, 2008).

In this project I have taken measures to reduce bias to the maximum extent. This was possible by adopting a variety of strategies and methods to minimise bias and thereby strengthen the rigour of my study. Therefore, I have referred back to the original transcripts during and following data analysis to ensure that the issues,

[36] Evidenced by a series of e-mails in **Appendix 19**

concepts and contextual realities have been suitably explored. Also, that it accurately represented the phenomena of the use of A&E records from the perspective of the staff that use them. By moving in a circular fashion between reflecting on my evolving account and my developing understandings, my reflective understandings changed as my interpretation of the participants' everyday practices evolved. I have reflected upon my own beliefs about the use of the records (a) the presumption that child protection can be improved by the use of shared record keeping, (b) the presumption that staff in A&E and other agencies perceive child record keeping as a process for safeguarding children, and (c) presumptions that records are fit for purpose. I thought that these assumptions would be relevant in the participants' everyday experience; hence I was using my own knowledge to assist me in understanding participants' reactions.

I realised that I needed to remain open to the possibility that the views that may have emerged may be different from the original concept. Then my thoughts, assumptions, values and reflections were all challenged, because I was not only responding intellectually, but also emotionally. Through the research I came to recognise that although my assumptions were important to the participants, they were not as central as I thought. I realised that my values and assumptions inevitably influenced how the research was carried out. I learnt that although participants thought that child records were a good tool for communication, they thought that the records were not sufficiently child focused; therefore risk factors were not always recognised. They thought that existing written records did not provide a format that enabled staff to record information comprehensively. They also thought that training was an important issue. Once I saw how my professional assumptions were biasing my perceptions of the participants' use of child records, I constantly returned to the phenomenon being analysed: the use of A&E records and the perspectives of staff. This ensured that the account was a true reflection of the reality of the participants.

I have made explicit my account of the methods used at every stage of my study, illustrated and justified my sampling strategy, described my field work in detail, reflected on my position as the researcher and the extent to which I have influenced the research process and data collection. I acknowledge that bias can seldom be

avoided totally, but as a researcher it is my responsibility to eliminate or avoid bias that can distort the results of the study.

5.17 Generalisability

This research does not attempt to generalise beyond the case study site, but it does seek to establish that it is trustworthy in one location (Stake, 2005). Transferability refers to the degree to which the findings of the research can be applied to other similar situations (Denzin and Lincoln, 2005; Polit and Beck, 2008). The work of Lincoln and Guba (1985 p.316) refer to transferability in the context of generalisation and argues whether findings 'hold in some other context, or even in the same context at some other time is an empirical issue'. Although this research does not specifically seek to make findings generalisable, this study relates to clinical practice, consequently, it was necessary to focus on the potential that this study could have on evidence based nursing practice. Therefore, generalisation played a role, as this qualitative research study seeks to understand in-depth the purpose and use of child records from the perspectives of the different professionals who share the information.

In order to deal with the issue of generalisability and to ensure that the results were accurate and valid, this study was designed to address issues of trustworthiness (Guba and Lincoln, 1985). In terms of trustworthiness, Bryman (2008) states that this is a position that relates to reliability and validity in which qualitative research can be discerned, and cites the work of Lincoln and Guba (1985) as the authority for judging scientific rigour of qualitative research. Other authors (Polgar and Thomas, 2008; Polit and Beck, 2010; Lobiondo-Wood and Harber, 2010) agree with this position. Therefore, in selecting the participants, the researcher needed to identify those to whom the results might be generalised. Thus, in this case they were members of the LOCP group and A&E staff (illustrated in **Tables 5.2** and **5.3**). These members were then included as participants in the study. This was in order to maximise exploration of different perspectives and to obtain a non-biased sample, as this study has implications for other LOCP groups and A&E staff.

The work of both Guba and Lincoln (1985) and Denzin and Lincoln (2005) inferred that qualitative researchers are encouraged to produce rich accounts of the

details of a culture. They indicated that a thick description provided others with an organised store of data for making judgements about the possible transferability of findings to other settings (Guba and Lincoln, 1985; Denzin and Lincoln, 2005). I have endeavoured to give a rich and thorough description of the research, the design and process used so that the value of the evidence can be assessed by others. Nevertheless, in this case it is difficult to know whether the same relationship would manifest themselves in other LOCP groups and A&E departments. However, it is reasonable to assume that some elements of this study may be transferable to other contexts (Crabtree and Miller, 1999).

5.18. Data Collection

5.18.1 *Stage one- audit of records*

A checklist/data collection tool (previously discussed) was used to record data from the records. The audit was conducted between 1 May 2007 and 5 November 2007. The average number of children between the ages of birth to 16 years visiting A&E per day was 63. For one 24-hour period a month on different days of each week for six consecutive months (26 weeks) a total of 378 (14.3%) out of a possible 2646 of the records were analysed. If the number of records on the day of auditing was more than 63, the first 63 were analysed. If fewer than 63, the first records taken out of the drawer for the following 24 hour period made up the number for analysis to 63 (**Table 5.4** shows number of records on days of auditing).

Month	May	June	July	Aug.	Sept.	Oct.	Nov.
Date	1st	6th	12th	17th	22nd	28th	5th
Day	Tues	Wed	Thurs	Fri	Sat	Sun	Mon
Number of records	87	58	80	54	79	44	68

Table 5.4 Number of records on days of auditing

There were two categories of records:

- Those indicating no cause for concern beyond the medical needs of the child;
- Those indicating cause for concern and a need for action.

This second category were analysed in detail after being divided into two groups:

- Those concerns that were identified by members of staff in A&E;
- Those concerns that were picked up by the PLHV alone.

There is no intention to represent this as a statistically valid sample. This provided the basis for finding out (a) how records were being used, (b) what readers did with the information, and (c) what was in child records.

5.18.2 *Evidence from records*

Robson (1993) believed that in the field of research, there is a considerable amount of interest in the analysis of written documents. He argued that by using information from a written document instead of directly observing, we are dealing with something produced for another purpose; therefore this differs from other techniques in that it is indirect. Furthermore, he indicated that by collecting data in this way is non-reactive, in that the document is not affected by the fact that you are using it therefore its non-reactivity can provide useful validation for other more central methods. This view is supported by the work of other authors in the field (Crabtree and Miller, 1999; Carter, 2002; Polit and Beck 2010), who argued that a qualitative researcher, in search of meaning, is concerned with collecting holistic aspects of the phenomena by documenting events or situations as they occur naturally, therefore data can be recorded with a minimum of structure. Thus in this study, not only the content, but the state, appearance, and accessibility of records were data that were considered as information rich and were characterised as complementary to enhancing the understanding of evidence obtained from the records (see also 5.10.1 critique of the use of records as a data source).

5.18.3 *Stages two and three - conduct of focus group study*

- Stage two - the LOCP group discussion took place in July 2007 and lasted 55 minutes. This group was used to obtain information about opinions and perceptions of child records in A&E, their content and use, and participants

were asked how and why they used these records (cross reference Chapter 6).

- Stage three - the A&E focus group discussion was conducted in August 2007 and lasted exactly one hour. In order to gain insight into the collective perceptions and opinions of how and why child records were used this group was asked the same question as the LOCP group (cross reference Chapter 6).

- Evidence from the records in stage one, and interaction between participants, such as group dynamics, differences and similarities in stages two and three of the study are included in the data collection, since they represent a fruitful area of what has been learnt. It was not possible to record everything that transpired during the focus group discussions; therefore the behaviour that was categorised was guided by the research question (discussed earlier see also in Chapters 6 and 7).

Each focus group discussion began with a preamble that included welcoming of the participants (environment discussed earlier). The purpose of the discussion was outlined, setting the parameters of the discussion (length, audio-taping, and transcribing); assuring confidentiality, and informing participants that there are no right or wrong answers, rather, it was their opinions and perceptions of the use of child records that was important for the study.

Prompts for the focus groups discussions (**Figure 5.5)**, provided a strategy for addressing the research question, as well as generating rich and diverse views, opinions and experiences from the staff's perspective. Both groups were facilitated by the researcher/PLHV. It was recognised that a conflict of interest could have been perceived; therefore, an impartial person took notes during both focus groups' discussions, thus duplicating what was being tape recorded (considered earlier in this Chapter). Both group discussions were audiotape-recorded and later transcribed.

Participants sat in a circle (seating discussed earlier and illustrated in Chapter 6 **Figures 6.7** and **6.8)**. Therefore, it was easy for them to look away from others if they wished. They all sat on the same level and type of seating, at a comfortable distance so that anybody speaking quietly could be heard (Salant and Dillman, 1994; Mays and Pope, 1996; Crabtree and Miller, 1999).

5.19 Reflexivity

Several researchers (Kolb and Fry, 1975; Bogdan and Biklen, 1982; Schon, 1983; Jarvis, 1992) concluded that integral to any research is the process of self-reflection. They have indicated that the process that leads to integrity is one of reflection on and acting in such a way that one's duty to one's self and duty to others are brought together in action.

5.19.1 *Reflection on audit of records*

I started my research recognising the importance of reflexivity to the research process. In this study as the PLHV who was also the researcher and facilitator of the research project, I received research training both at graduate level, in good clinical practice and research governance (research training certificate of attendance shown in **Appendix 2**). Nonetheless, before commencing the audit of the records and data collection, I tried to clarify my understanding about the complexities of the sharing of information by means of A&E records. Armed with my research training, my knowledge, skills and experience as a PLHV, I felt they were more than adequate to cope with collecting information from these records.

The work of Schon (1983) describes this process as being the professional rules to routine and the situations that are met in the day to day work of the professional. Although confident that I had the knowledge to collect the appropriate data for this study, as a beginner researcher I felt that this knowledge alone was not only limiting to both myself and the study but it could be damaging to both. Therefore, during the auditing of the records, if I was in doubt of whether or not a piece of information was useful I would write it down, as I was uncertain of what it would eventually contribute to the understanding of the use of these records (Hammersley and Atkinson, 1989).

As the researcher my own inner feeling made me want to provide the best data for this project. Therefore, as I was working alone I focused on three issues. Firstly, that it is important that I abide by the ethical principles of research. Secondly, that accurate and relevant information to safeguard and promote the welfare of children was demanded by my practitioners' codes of conduct. Thirdly, improving information sharing practice is the cornerstone of the Government Every Child Matters strategy to improve outcomes for children. Consequently, my attention was then drawn to the decision making process such as, what to record, and how to handle this privileged information and understood that as a researcher auditing these records that self -reflection/self- criticism is an active part of interpretation.

Through the process of reflection, I have learnt that each record that I have audited as a researcher added a new dimension to my experience as a practitioner. Whilst making use of my knowledge and experience to audit the records in this study I have learnt that no matter what my feelings are about the use and purpose of these records, I should no way impose those feelings on the data collection for this project. I have also learnt that utilising my positive feeling was important in this project as it provided me with the impetus to persist in what was a challenging situation.

5.19.2 *Reflection on focus group discussions*

I was sensitive to the fact that my behaviour had to be appropriate whilst I was in the field. So, during the focus group discussions there was a need for me to be aware of and observe what was actually occurring, specifically how I was interacting with the participants and influencing the process. To illuminate this I offer a reflection from my diary of the first focus group discussion: here whilst sitting on a chair near the centre of the other participants and near the tape recorder, I was simultaneously trying to hear what was being said and reacting in such a way that was supportive and non-judgemental of the group. I suddenly became very aware that in order to monitor non-verbal communication extensive notes could not be taken therefore my behaviour had to be appropriate in order to take brief notes on non-verbal communication e.g behaviours, body language, gestures, eye contact and that all members participated.

The experience you have in the field are not merely observed and recorded, they are also felt (Crabtree and Miller, 1999). I realise at this point that I was less secure than I thought about being in this particular setting. I felt then that my thoughts, assumptions, values, and reflections were challenged. For, I was not only responding intellectually but also emotionally. Once I realise this I chose to change my behaviour, I did not want to deny the participants and myself the opportunity to learn from all of their feeling states, including those of frustration, anxiety, sadness, and anger, so therefore, I did two things differently. First, I made a conscious effort not to send cues that would shift the feeling state, for example, tone of voice, and eye contact.

I acknowledge the fact that focus groups are difficult to manage, during the sessions at times dealing with both focus groups appeared problematic, as I did not consider myself well equipped for the management of such group discussions, and this made me feel irritated. However, as I reflected on my irritation I conceived that this came from my subjective view of feeling as a novice. I associated my difficulties with a deep rooted need for expertise without which I felt that I would not be able to analyse my new experience relating to the study with confidence but I understood that this will take time. I recognise the key to my frustration to be my lack of experience as a researcher. I realised therefore that I needed to re-evaluate my own values which ultimately will have an effect on my values and those of my colleagues enabling them to feel they had autonomy over their own practice.

Following the first focus group it was not necessary to change the strategies and processes used. This happened as a result of learning more about group space and personal space, the environment and also being afforded a little more experience because I had already conducted one focus group. Following the second focus group, comments received from one of the senior nurses two days later, was that the group found the discussion interesting and they were requesting that such group discussions became a regular feature, because they considered it a very useful as part of the safeguarding children training programme. Ethics and responsibility has guided me every step of the way this includes the way I was positioned as a researcher within and beside the focus groups with whom I worked (see also Chapter 10). Only through such reflection can the researcher determine how he or

she is influencing the field experience. As the principal researcher and eyewitness to my own project, I acknowledge that I was subject to fallibility of recall at all stages of the reflective process whether these relate to fact or feeling.

5.20 Data Analysis

Analysis was informed by a social constructionist epistemology (Berger and Luckmann, 1967) and drew on existential phenomenological concepts (Heidegger 1962). This approach to data analysis in phenomenological research is challenging and involves hermeneutic interpretation of evidence which is largely descriptive (Crabtree and Miller, 1999). Existing literature does not make clear distinctions between descriptive/interpretive and theory building analysis procedures (Watson et al. 2008). The absence of systematic analytic procedures makes it difficult for the researcher engaged in qualitative analysis to present conclusions in such a way that their validity is patently clear and, in the absence of fewer standard rules and well-defined, universally accepted procedures, replication is made difficult (Crabtree and Miller, 1999; Mays and Pope, 2006).

This analysis of meaning is deconstructive which remains closely tied to the text it interrogates; it has its roots in Greek philosophy and is commonly used by Heidegger (1962) as deconstruktion, but is commonly informed by the writings of Jacques Derrida (1976) which focus on evidence of linguistic origins of meaning. In the everyday research settings, disjunctives are not straight forwardly managed, as there are a variety of methods people use to minimise epistemological issues about reality and understanding. Hence, management is sensitive to features of the activity. Therefore, the deconstructive approach dismantles a text, locating contradictions and assumptions, and examines it, paying particular attention to prejudice and bias that the author might have used for purposes of control. As these elements of the text are brought to light, the researcher moves through successive stages of self-reflection, this commences with the text in the fieldwork experience, through the intermediate work and finally to the research text which is for public presentation. In light of this, the research was designed as a reflective qualitative case study with the intention of uncovering the importance of the human element, such as staff value and perception of documentation and communication by means of the research process itself. The staff in A&E and the LOCP group who

participated in the study judged the truth of the findings. This was achieved by ensuring that the findings of the study were compatible with descriptions and explanations that were recognised and understood by the participants.

Whilst there is no agreed approach for analysing data of this type, there are good frameworks presenting guiding principles. Colaizzi (1978) presents seven procedural steps for analysis based on Husserlian phenomenology (shown below in **Figure 5.6**). He developed this approach from the Duquesne (Husserlian) school of phenomenology and his method is frequently used to understand the lived experience (Bryman and Burgess, 1994; Coffey and Atkinson, 1996; Crabtree and Miller, 1999; Draucker, 1999; Langdridge, 2004).

Colaizzi's seven procedural steps:-

- All of the subjects' descriptions from the protocols (transcripts) are read in order to make sense of them.

- Extract each description or sentence directly pertaining to the investigated phenomenon, these are known as significant statements. They consist of a summary description with illustrative quotes followed by an interpretation.

- The underlying meaning of each significant statement is called a formulated meaning. Try to spell out the meaning of each significant statement. This step is a precarious leap (Colaizzi, 1978) as it moves from what the participants said to what they meant. It involves the researcher being cognisant of contextual factors that modify the meanings of the verbatim transcripts.

- The above process is repeated for each description and the aggregate formulated meanings are then organised into clusters of themes.

- These clusters of themes are then referred back to the original protocols in order to validate them.

- An exhaustive description of the phenomenon.

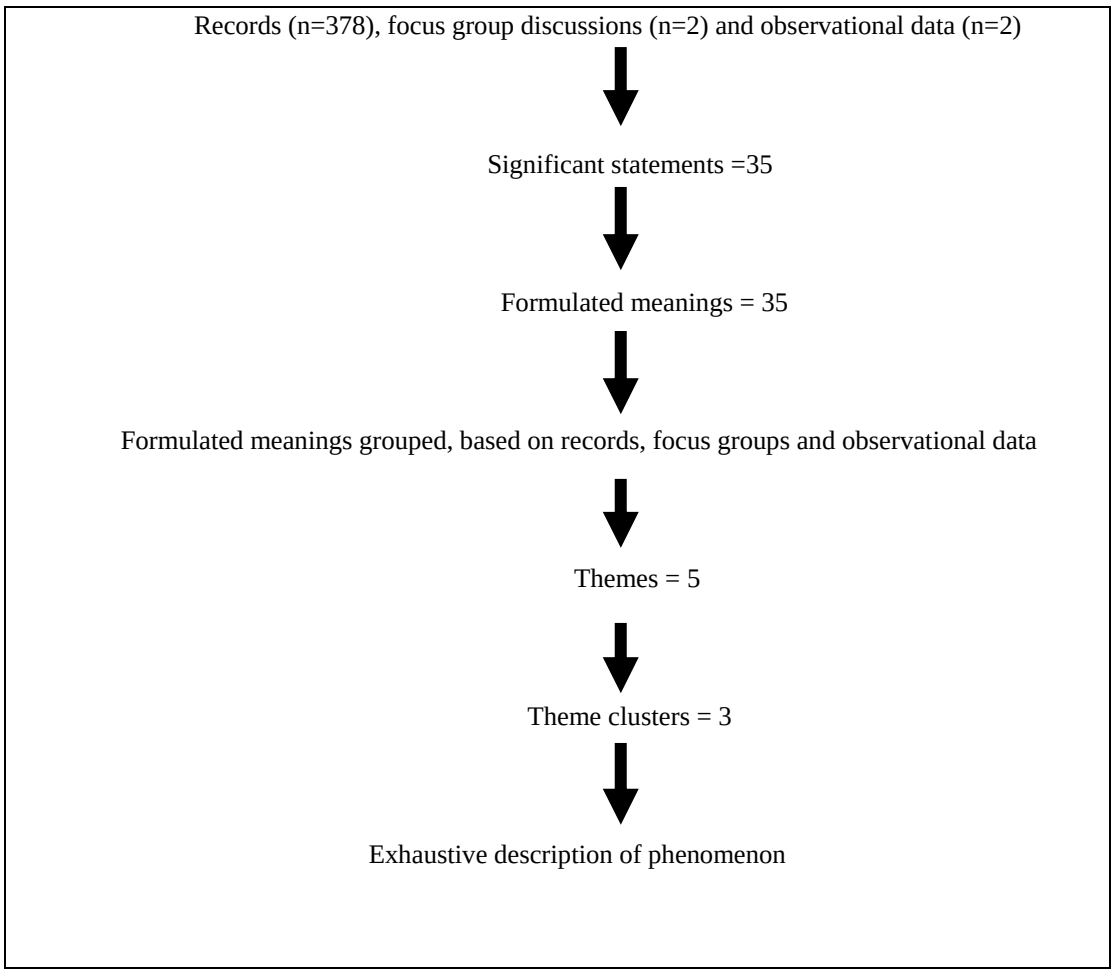


Figure 5.6 Summary of data analysis (adapted from Colazzi 1978)

Colaizzi's (1978) phenomenological psychology offers four sources of descriptive data for a phenomenological study. The four sources are written descriptions, dialogue interviews; observation of the lived events; and imaginative presents. Each source of data selected has a corresponding, descriptive method of analysis. In this case, written descriptions were the source of data selected. Therefore the audit of records, focus group discussions and observational data were used to address the importance of the human element on documentation. Thus Colaizzi's (1978) protocol analysis is the method used for scrutinizing the written descriptions of the phenomenon being studied.

The process in this study[37] extended from the start of data analysis of all three stages of the study to the subsequent reading and validation of the information. The analysis began by scrutinising the data from the records, focus group discussions, and observational data carefully and deliberatively, and by reading each informant's verbatim transcript/protocol[38] to acquire a sense of the whole. The data was read over and over again in search for meaning and deeper understanding. Until the researcher becomes completely familiar with the data, understanding of what the participants are trying to say will not emerge clearly (Colaizzi, 1978; Morse and Field, 1995; Kruger, 1997; Crabtree and Miller, 1999; Polit and Beck, 2008). Whilst reviewing the transcripts, notes were made of significant statements recurrent themes and issues, which emerged as important to the participants, were jotted down. Having gained an initial overview of the data from the transcription of the records, two focus group discussions and observational data, I began to concentrate on exploring the data more deeply and moved into extracting significant statements. Each transcription, called a protocol (Colaizzi, 1978) was read several times to gain a sense of the total content. Significant statements pertaining to the phenomenon being studied (the use of A&E child records) were extracted from each protocol and numbered. A total of 35 significant statements derived from the protocols, nine from the records, twelve each from the two focus groups and two from the observational data. Examples of significant statements are shown below.

5.20.1 *Examples of significant statements*

Significant statement 1

Unfortunately, only 24 of the records indicated that a cause for concern had been identified by the A&E staff (records).

Significant statement 2

"I think when there are problems there needs to be a quicker way to deal with the records, I always get the feeling that it needs more urgent attention. It always happens out of hours it always happens at weekend , it always happens at nights is

[37] See **Figure 5.7** below
[38] See **Appendices 11-13**

there somewhere I can write urgent without writing it about twenty times or whatever" (A&E focus group).

I then moved to formulating meanings from the significant statements and the underlining meaning of each statement was written. The underlining meaning of each significant statement, called a formulated meaning was given the same number as the significant statement from which it was derived (examples of formulated meanings shown below). This step moves from what the participant said to what they meant. According to Colaizzi, (1978, p.59), this step is a precarious leap and it involves the researcher being cognisant of the contextual factors from the transcription of the data. As the researcher to ensure that I remained true to the data, I undertook to refer continually to the transcriptions/protocols of the records, two focus group discussions and observational data.

Examples of formulated meanings

Formulated meaning 1

When different knowledge and understanding are used during the initial definition and recording of history the response to assess the child's needs may be affected.

Formulated meaning 2

Staff member is experiencing a dilemma which makes it difficult to provide appropriate care for the child.

5.20.2 *Organising formulated meanings into themes*

Next, the formulated meanings for all of the data from the protocols (records, two focus groups and observational data) were then combined. The next step in the data analysis was to organise formulated meanings into themes that were common to the protocols. The formulated meanings were sorted into groups that represented specific themes. Each theme was numbered and each formulated meaning that formed part of a particular theme was listed beneath it. For example below are themes 1 and 2 with their associated formulated meanings ((illustrated in **Figure 7.1**).

Examples of themes

Theme 1 - Communication and Power

Formulated meaning

Communication, and its relationship with social interaction, status, power and process, impacts on staff behaviour, as a result impacts on the provision of care for the child.

Theme 2 - Staff passivity- disengagement with the process of assessment.

Formulated meaning

The complexities of systems and processes creates difficult circumstances which made staff passive and disengaged with the process of assessment, thereby making it difficult to provide appropriate care for the child.

5.20.3 *Organising theme into theme clusters*

The next step in the analysis of data was to organise similar themes into theme clusters. For example, theme cluster 2 is assessment and the cluster of themes, are listed below and illustrated in **Figure 7.3.**

Theme cluster 2: assessment - issues that impede appropriate care for the child to be provided:

Theme 2 - Staff passivity - disengagement with the process of assessment.

Theme 3 - Recording – record production.

Theme 4 - Non- adoptive/adoptive approaches to hospital management.

An interpretive outline then formed the thematic interpretation of the records, focus group discussions, and observational data and proceeded through the steps as outlined in the summary for data analysis model (**Figure 5.7** below). From the wealth of information obtained, the next step in the analysis was to produce an exhaustive description of the phenomenon being studied. The results of everything were then integrated into an in-depth explanation of the investigated topic. This goes beyond mere fact or surface appearances, but stops short of becoming trivial and mundane, thus, enabling the provision of a complete report of the lived experience. Therefore, an exhaustive description should communicate the feelings, actions and meanings of the interacting participants in this study (Colaizzi, 1978; Field, 1995; Crabtree and Miller, 1999; Polit and Beck, 2008).

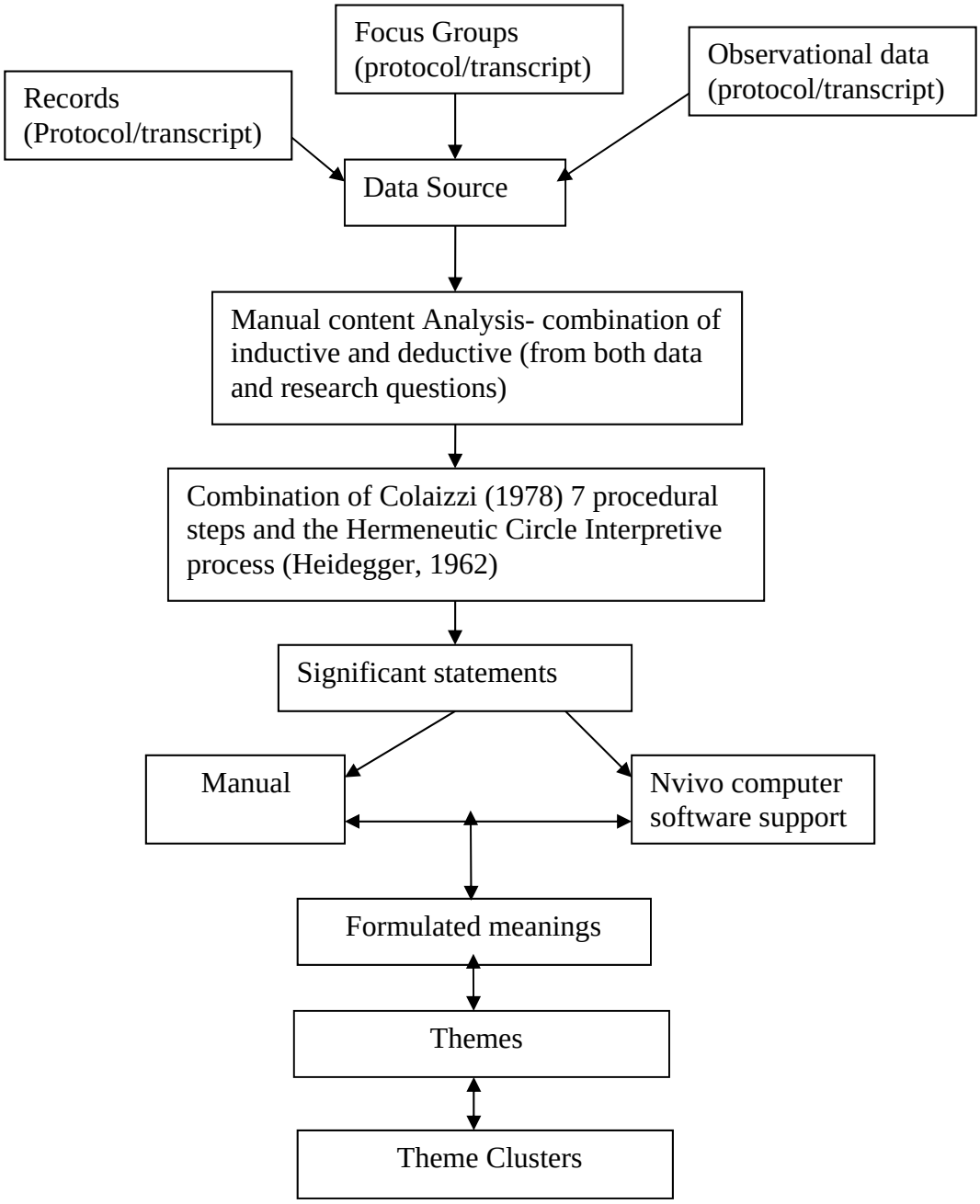


Figure 5.7 Model for data analysis

5.20.4 *The hermeneutic circle*

The hermeneutical interpretation is made up of interwoven processes, these are thematic analysis, interpretation of exemplars, and interpretation of paradigm cases which can be considered as the hermeneutic circle (**Figure 5.8** below). This represents a methodological process in which there is continual movement between the parts and the whole of the text under analysis. Hermeneutic phenomenological research characteristically starts with data of descriptions of the lived experience,

but this approach enables the researcher to go beyond the surface or explicit meanings and to read between the lines, in order to access implicit dimensions and intuition (Benner, 1984; Polit and Beck, (2008)).

The process of reading between the lines generates uncertainty, or going beyond what a person has said and entering into the realm of interpretation (Colaizzi, 1978; Draucker, 1999). Analytic interpretation is not an additional procedure; it constitutes an inevitable and basic structure of our being in the world (Heidegger, 1962). Analysis is therefore articulated by both the researcher and the participant, but the roles of both need to be clear (Draucker, 1999; Lopez and Willis, 2006). This step moves from what the participants said to what they meant. It involves being cognisant of the contextual factors that modify the meanings of the verbatim transcription of the protocol. Creative insight is needed for this 'precarious leap' from what the participants verbalised to what they meant to convey (Colazzi, 1978). In this step, whilst the attempt to discover hidden meanings is made, in order to ensure that I remained true to the data I did not sever ties with the original protocols (Colazzi, 1978). Similar views are held by other authors (Lopez and Willis, 2004) who argued that the research participants' use of jargon, phrases and expression of strong emotion, can alter the meanings of the verbatim transcription.

An explanatory drawing, based on the work of Heidegger (1962) depicts diagrammatically a process whereby experiences and preconceptions of both participants and researcher are combined throughout all stages of the research process (shown in **Figure 5.8**). Heidegger (1962) developed the concept of the hermeneutic circle to envision a whole in terms of a reality that was situated in the detailed experience of everyday existence.

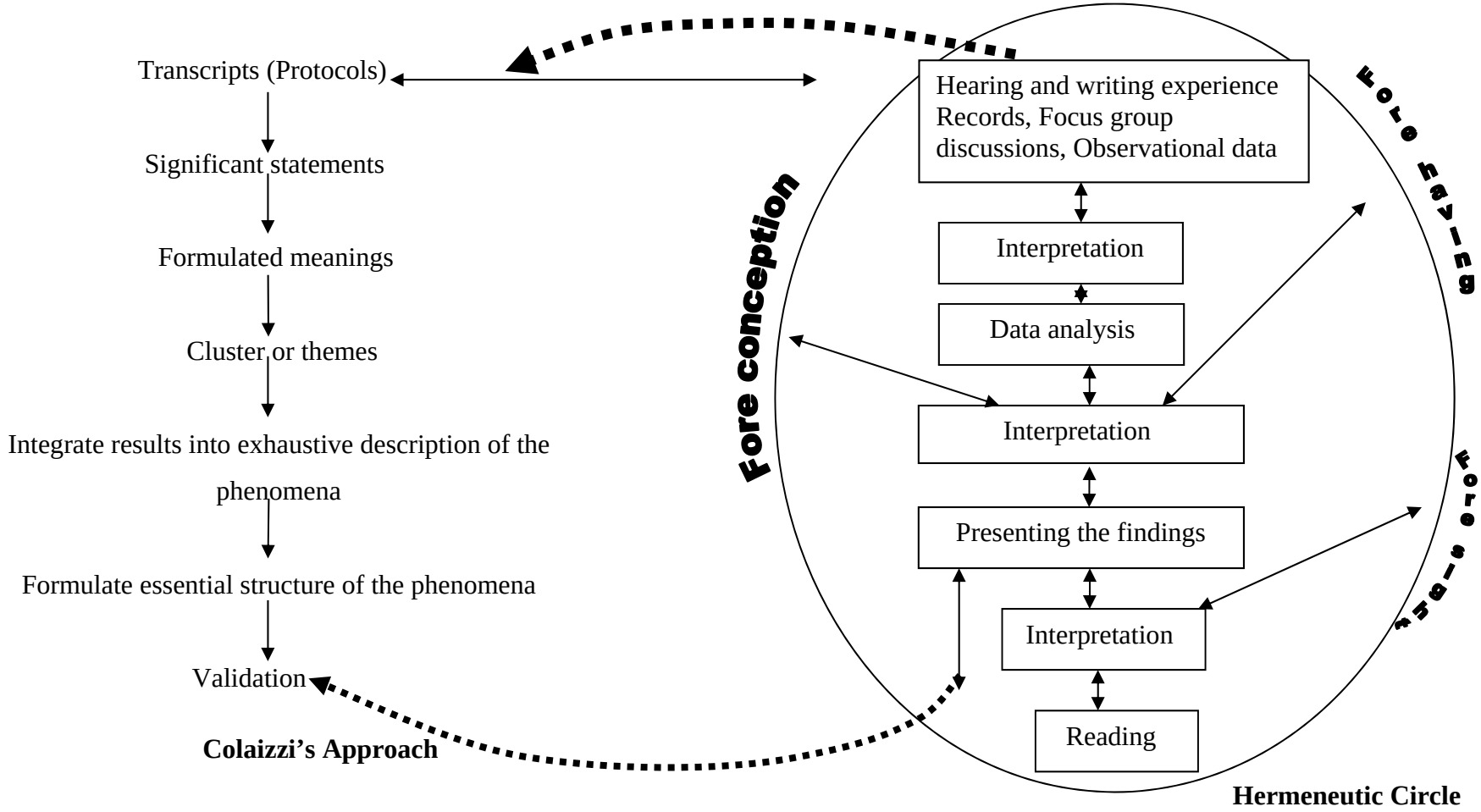


Figure 5.8 Diagrammatic Representation of Colaizzi Approach (adapted from Colaizzi 1978) and the Hermeneutic Circle Interpretive Process (adapted from Heidegger 1962).

As a result, understanding could be developed on the basis of fore having, foresight, and fore conception, that allowed phenomenon such as the use of A&E child records to be interpreted. Events have a certain meaning for us; therefore interpretation will essentially be found in our fore-conception (Hammersley, 1990; Robson, 1993). Thus the analyst brings their fore conception to the encounter and cannot help but look at any new stimulus in the light of their own prior experience. Hence, in this study, the hermeneutic analysis process allows for the experiences of the researcher and participants to converge. It also acknowledges that the researcher's preconception and background becomes part of the interpretive process, as they are integrated and articulated through the data analysis meanings.

In this study the focus involved the explanations or meanings of information emanating from the participants involved (Gadamer, 1989; Cohen and Omery, 1994). Therefore, as the reality laid in the participants' own construction of their use of the A&E records, the data analysis was guided by the research design. For that reason, meanings, variations and perceptual experiences of phenomena are explored by using themes captured in the data to provide a meaningful whole. Hence, a hermeneutic phenomenological analysis using Colaizzi's stages (1978) and the hermeneutic circle (Heidegger, 1962) were utilised (demonstrated in **Figure 5.8**). They were pooled to provide a rich description of the essential structure of the phenomenon.

5.21 Categorising and coding

Computer programmes were initially considered to manage classification and organisation of themes within the data. These programmes are particularly useful in organising large amounts of data (Polit and Beck, 2008). Although the volume of qualitative data in this study was small, the analysis benefited from the support of Nvivo, a computer software programme commonly used for analysing textual data, for it allows connections between the study, other texts, documents, or nodes, thereby allowing the researcher access to selected text for coding (Crabtree and Miller, 1999; Polit and Beck, 2008). There were many advantages to using NVivo which included: ease of coding and recording data, ease of management and retrieval of data; and writing and retrieval of memos. The software also automatically kept an audit trail of the analysis process.

5.21.1 *Cutting and sorting*

However, because the amount of data in this study was small, it was practical to utilise the traditional manual technique of cutting and sorting data as well as NVivo. The process of cutting and sorting offered the opportunity for the flexibility of spreading the data on to a table. This assisted quick reinterpreting of data into different headings. Themes emerged through the organised notes; this enabled me to cut up data according to each heading and to add sub-headings. The data was analysed using both the computer assisted qualitative data analysis software and by hand. Therefore, themes were developed based on careful manual scrutiny of the actual data with additional support from NVivo (see Chapter 5). The data source for analysis came from the transcripts/protocols of records, two focus group discussions, observational data and literature. The data from the focus group discussions was transcribed verbatim, and the printed version of the word processed transcripts was explored manually to maintain data integrity and minimise biases. All data was saved in a rich text format and imported into the NVivo programme. The information was then hand coded, different colours were used for each significant statement. As previously stated a total of 35 significant statements came from the data source, nine from the records, twelve from each focus group and two from the observational data (see Chapter 7).

Headings were created both inductively and deductively as they emerged from the data and research questions. The data was then categorised into five broad themes. These were: communication and power; staff passivity-disengagement with the process of assessment; recording, which includes record production; non-adoptive/adoptive approaches to hospital management; and imbalance in professional knowledge (training). These groupings, which formed the structure of the classification, were then coloured with a highlighter pen. The colours were then sorted into piles representing theme clusters (as illustrated in Chapter 7).

Coding or indexing (see Chapter 7) is seen as a key process since it serves to organise copious notes, transcripts, or documents that have been collected. It also represents the first step in the conceptualisation of the data. (Bryman and Burgess, 1994; Coffey and Atkinson, 1996; Watson et al. 2008). It has also been suggested by other researchers (Bryman and Burgess, 1994; Miles and Huberman, 1994;

Langdridge, 2004) that organising the data in this way is considered to be an essential part of the process of analysis. This is because it involves some concrete manual activities, which aids scientific rigour. The purpose of coding, in this study, was to aggregate all data concerning the same theme in order that each piece could be studied individually.

5.22 Conclusion

This chapter sets out the main concepts and theories that have provided the base on which I have designed and implemented my study. A social constructivist approach has been used to explore staff value and perception of documentation as it unfolded over a period of six consecutive months. This approach offers flexible evolving procedures throughout the research process that enable the researcher to uncover the story of how A&E records are used. Given that this study focused on the social constructs of the way child protection issues regarding communication are perceived in everyday life, it sits within an interpretive paradigm. Therefore, a hermeneutic phenomenological epistemological framework was utilised to ensure that participants have a direct voice in their representation of communication to other colleagues. Since it is their perspectives and experiences that would give a realistic explanation I am guided by their opinions. This study also provides participants with the opportunity to participate in the decision making process of improving documentation and information sharing. One cannot presume to know at the outset what the perceptions, views and understanding of the use of child records are when diverse staff share the information. This research methodology will only give access to a selected part of reality. The key question design, which is an interpretive exploration of the purpose and use of A&E child records and the purposeful sampling of materials, will only open a small window of what is occurring. We can endeavour to select, record and communicate pertinent information to other colleagues in order to safeguard children. However, it is only when we forget to examine our documentation for factual value and take appropriate action, that we allow ourselves to fall victim to circumstances. The following chapter presents the research findings from the study.

Chapter 6 Findings

Introduction

This chapter presents the findings of the fieldwork from all three stages of the study. In view of the fact that this research involved the meanings of what people say and record, the examination of the data is based on a hermeneutic phenomenological analysis process as described in Chapter 5. In the first stage of the study, documentary evidence was drawn from a purposeful sample of audited records, and, in the second and third stages data was collected from two focus groups' discussions together with observational data. Thus, noteworthy results are offered, as they were fruitfully exploited to answer the research question, and were useful in providing an intimate description of how records are used and relate to the issues of meanings and truth. In other words, what happened in everyday life in A&E. The accompanying interpretative comments are based on the observational data which includes non-verbal communication behaviours, group dynamics, differences and similarities, as they represented useful areas of what has been learnt from being in the research setting.

6.1 Findings from audit of records

A total of 2646 children were recorded as having attended the A&E department between 1 May 2007 and 5 November 2007. Of these records, 14.3% (n=378) were audited (shown in **Figure 6.1** below).

Figure 6.1 records audited

An overall evaluation in line with Standard 5 of the National Service Framework for Children (DH and DfES, 2004) and the Trust Record Keeping Policy (2004) showed that in 73 (19.3%) of the audited records, a cause for concern was evident and was identified by the PLHV; but in 49 of these records the A&E staff had failed to highlight the concerns. This shows a significant shortfall, because in accordance with the recommendations of the Laming report (2003) and the Royal College of Paediatrics and Child Health (RCPCH, 1999; 2007) the role of the PLHV is intended to be that of a safety net.

If the professional attending to the child highlights a cause for concern, not only does this ensure an efficient, accurate handover, but it also avoids misunderstandings and discrepancies. This professional should also have a complete picture regarding behaviour, concern or any other non-medical indications pertaining to the child and family, since it is crucial for parents to be aware that a referral has been made (Armstrong, 1996; DfES, 2004a; Munro, 2005 HM Government, 2010).

The number of previous attendances were recorded within the records in every case. However, specific questions were not completed on all the records. The two principal regularly omitted categories were ethnic group and date and time of incident/accident (**Table 6.1** below shows details in the 73 records).

Details in the 73 records			
	Details	**Recorded**	**Not recorded**
1	**Ethnic Group**	**2**	**71**
2	**Date and Time of Incident/Accident**	**5**	**68**
3	**Date and Time seen by Professional**	**66**	**7**
4	**Next of Kin/Relationships**	**68**	**5**
5	**Accompanied By**	**69**	**4**
6	**Postcode (First 3 Digits)**	**71**	**2**
7	**Date and Time of Arrival**	**72**	**1**
8	**Sex**	**72**	**1**
9	**Date of Birth**	**73**	**-**
10	**Number of Previous Attendances**	**73**	**-**
11	**Mode of Transport**	**73**	**-**

Table 6.1 Details recorded in the 73 records

Ethnic group - 2 out of 73 records had ethnicity recorded. This indicates that comprehensive and contemporaneous records were not made (DH, 1989).

Date and time of incident - in 68 out of 73 cases they were not recorded. One of Laming's (2003) recommendations is that this should be recorded to enable the monitoring of issues, for example, late presentation of an injury. For any delay in presentation may be regarded as a failure to meet the child's needs. In some cases, it is possible that parents are not accessing GP services appropriately. In others, the reasons may range from a lack of knowledge to neglect. Whatever the reason for the delay, assessment of their needs may be hindered if the information on the date and time of the incident is not recorded in the first instance.

If the records are illegible, or they are not filled out with the appropriate information, or case history is incomplete, it is difficult for health and social care professionals to subsequently provide appropriate care. In the 73 cases audited, a complete history was only recorded in 7. This means that in 66 cases, a complete history was not recorded. **Figure 6.2** below shows the number of records where the history was legible, the records complete and where a cause for concern was identified (criteria for analysis of records see Chapter 5).

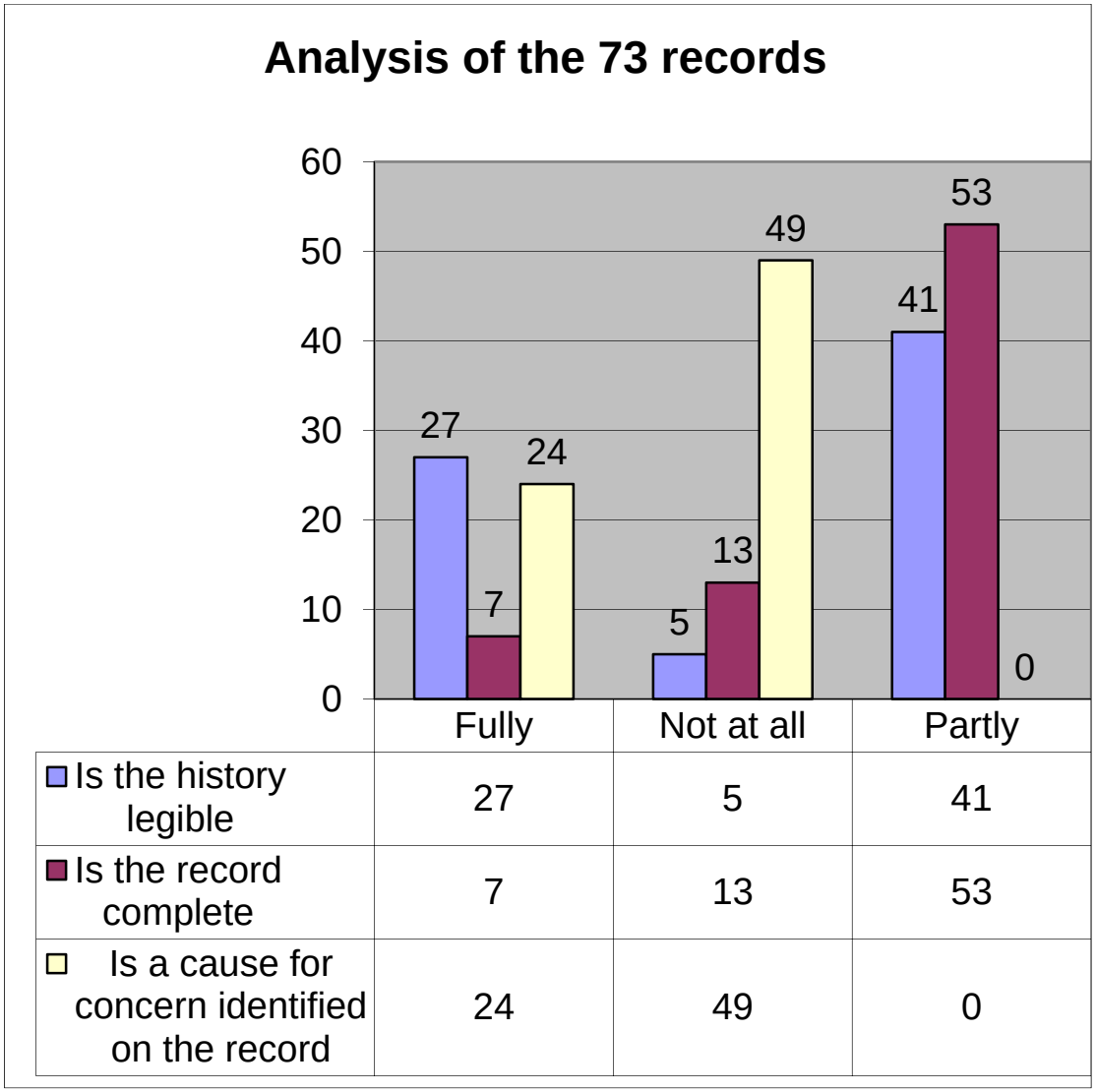


Figure 6.2 Analysis of the 73 records

Most records indicate further contact or referral (**Figure 6.3).** Where the records were complete and/or a cause for concern was identified, 67 had follow-up appointments or referrals to specialist practitioners or other agencies recorded and six did not. This is important as it indicates here that six children were not dealt with correctly; therefore, this could have affected their health and wellbeing. One of the key aspects of safeguarding children is that the child should be referred to the appropriate services/agencies (Laming, 2003; 2009; DH, 2004; HM Government, 2006). Hence in order to meet their needs, it is important that a referral is made appropriately, in so doing effective measures can be provided to safeguard and promote their welfare. Thus it is crucial that once a concern has been identified that a pertinent referral is made.

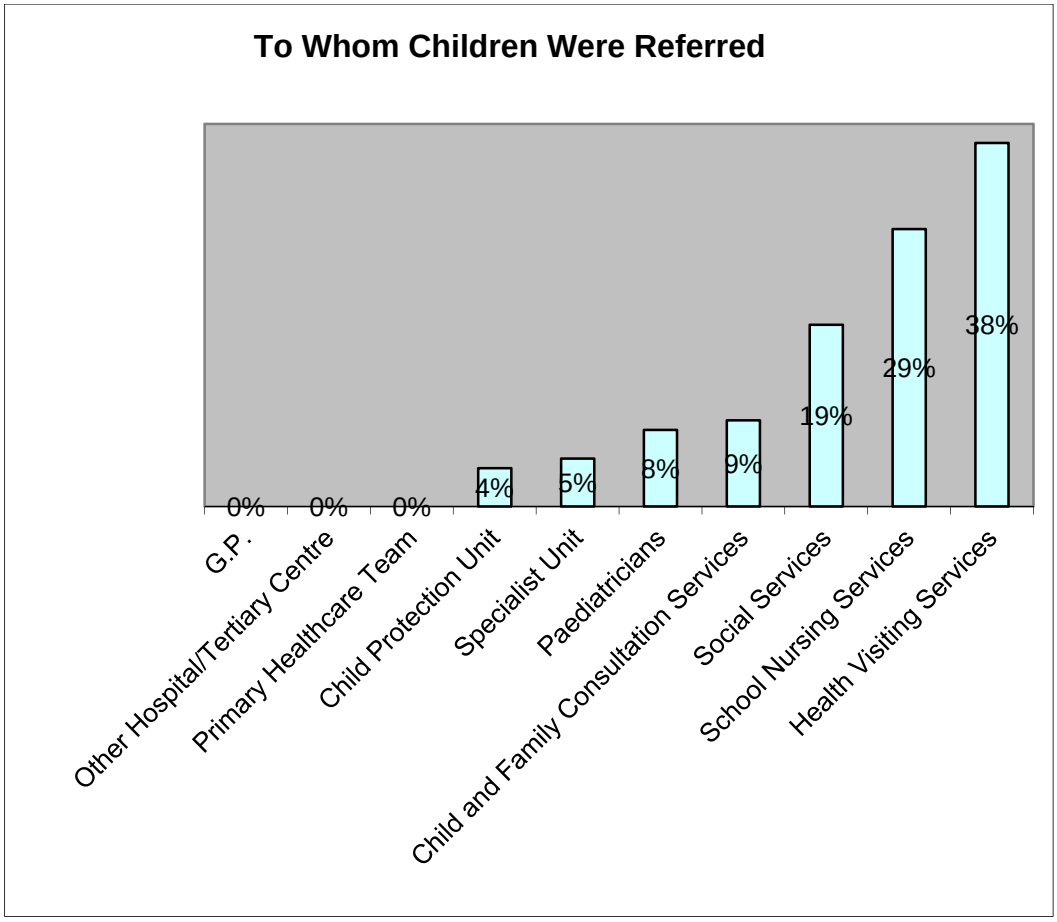


Figure 6.3 to Whom Children Were Referred

It is also essential that professionals in a health and social care environment share information that is appropriate. Otherwise, the primary function of investigating possible child abuse or children at risk could be impeded ((Laming, 2003; 2009; HM Government, 2010). In the chart (**Figure 6.3**), in some cases the same children may have been referred to two different agencies, for example, health visiting and social care services.

The results also highlight that due to issues regarding content and accuracy, there were certain failures in compliance to record-keeping and/or A&E procedures to reflect best evidence-based safe practice in record keeping policies and procedures for safeguarding children. Of the 73 children who attended A&E and were identified to be at risk, the frequencies and nature of the risks noted are shown in **Figure 6.4** below, any other concerns relate to children who needed support from social care, the health visiting or school nursing service, A&E staff had not

highlighted the cause for concern in 49 of these child records. This means that 49 of these causes for concern were identified by the PLHV.

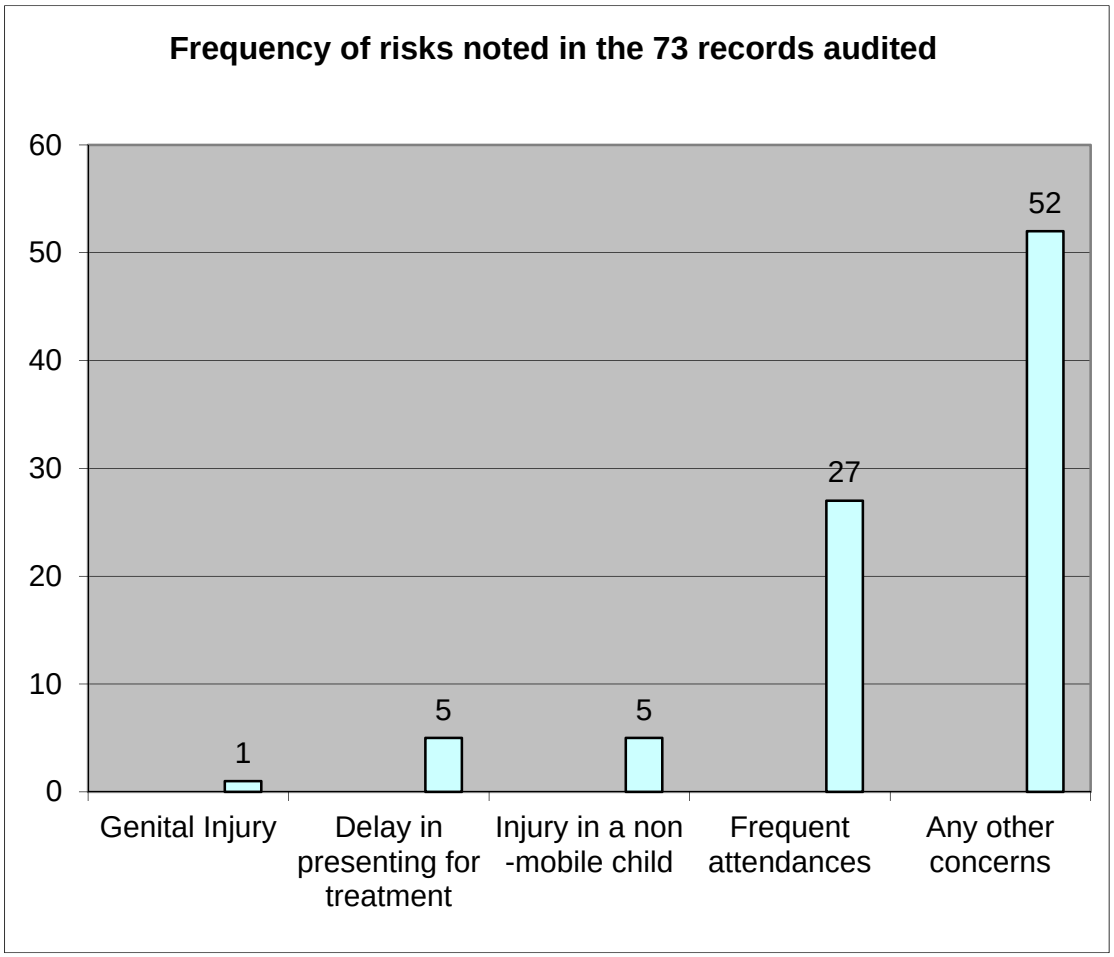


Figure 6.4 multiple risks

This is relevant; as it is contrary to safe and effective practice for the PLHV to be the main/primary source of highlighting a case to be one of concern and then present the referral to the necessary agencies (examples of any other concerns are shown in **Figure 6.5** below). It is also significant to note that as the date and time of incident/accident was only recorded in 5 out of 73 cases this meant that the data for the nature of risk listed in the chart above could not be accurately assessed. Nevertheless, this information has significance for not only is it important for the general population of children, it may be particularly so for the transient population, as evidenced by the circumstances surrounding the case of Victoria Climbié (Laming, 2003).

Inconsistent history
Alleged assault by step father
Wrist injury-multiple scars
Address given as back of father's van
Re-attendance within two hours
Intoxication
Unexplained burns in a child with severe autism
Found unconscious in a park
Multiple previous history of overdose
Withdrawn
Parents not attentive
Lacking personal, social and sex education
Signs of general distress/agitation
Appears scared
Unaccompanied
Brought in by a stranger
Not interacting with parents
Behaviour of parent.

Figure 6.5 Examples of any other concerns

Frequent Attendances should be closely monitored (Laming, 2003). It may be the case that some of these children should have attended their GP surgery, but also there may have been safeguarding issues as illustrated in the cases of both Victoria Climbié (Laming, 2003) and baby Peter Connelly (LSCB, 2009; Laming, 2009).

A complete history is essential in every case of injury in a non-mobile child, as this enables an assessment to be made as to whether the details supplied by the parents/carers correspond with the injury/incident (DH, 1989; DH, 2004; DfES, 2004a).

6.2. Evidence from of audited records

Locally agreed practice, dictates that all A&E records of children (birth - 16 years) must be made available to be read every day by the PLHV**.** Below are examples of evidence taken from the records (discussed in **Chapter 5**). It was recorded, in 47 out of the 73 records that were audited, that parents provided the history, even though most of the children were at an age where they were able to provide their own.

It is possible that when the history is taken from a child, staff may be influenced by variables associated with non-adherence to processes. For example, lack of failure to consider the child's level of intellectual development, and the degree to which there are concerns and feelings for the child's welfare. There may also be issues associated with short comings in communication skills. As a result when a member of A&E staff is confronted with a parent who insists on speaking on behalf of the child, they may feel that their professional competence is being challenged. This indicates that their ability to elicit the relevant information is limited, because they are unable to establish trust, thereby, not gaining the parent's cooperation. Consequently, particular attention needs to be focused on providing appropriate education and training.

1) Records can sometimes be missing for days, weeks and even months (Forge, 2006). The records can also be found in inappropriate places, for example, pigeon holes, cupboards, carrier bags, behind computers, found in other departments, and returned by internal mail without explanation. Records which do not contain any information are brought to the attention of practitioners, mainly doctors, but are still not completed for days. When found, the records are sometimes folded into pocket size. Pens with various coloured inks are used, mainly by doctors. For example, blue, and occasionally red (black ink should always be used in accordance with Trust policy). Sometimes the records are blood splattered and sometimes dirty. Perceptions on the use of child records are especially important in A&E, as it influences how and what is communicated to the healthcare team and others. There does not appear to be any one person with particular responsibility pertaining to records and record keeping. As a result, it appears that there is inadequate compliance to record keeping policies and procedures; therefore these records may not be valued because of the afore-mentioned reasons.

2) When issues regarding content and accuracy are brought to the attention of senior nursing and medical staff, their reactions are mixed. Some staff are concerned, others dismiss the issue as being trivial, and sometimes the doctors blame the nurse (for incomplete records, etcetera) and vice versa.

The fact that the records are sometimes illegible or incomplete increases the difficulty for another professional to assess a child's needs. This affects the ability of other professionals in health and social environments to fulfil their roles in terms of the safeguarding of children (DH, 2004; HM Government, 2010). Although the A&E staff provide documentation each day, this does not mean that they are competent in communication skills. It is, therefore, possible that there are different understandings of the content and accuracy of documentation. Some staff may consider the content and accuracy of the documentation trivial, because they themselves cannot cope constructively with the implications associated with poor documentation. In order to provide an illustration and enhance the understanding of the evidence offered from the observations of the records, see **Figure 6.6** below.

Page 1	Demographics such as name, address, and age are recorded *This page had mostly been completed* (98 %).
Page 2	The written content on page 2 is considerable, contains a heading and a consent form for medical or dental investigations, treatment or operations. *This page was mostly completed* (95 %).
Page 3	Contains a heading coma scale over 5 - under 5, this is a densely printed page in small font sizes and a variety of lines, and dots. *Very rarely completed* (5%).
Page 4	Consists of a body map. *Very rarely completed* (5%).
Page 5	The first part of page 5 shows the map of a head, hands and feet and below this an admission checklist of patient valuables and a discharge checklist of two lines. *Very rarely completed* (5%).
Page 6	For recording multidisciplinary notes in free hand. *Sometimes illegible and incomplete* (62.5 %).
Page 7	For recording multidisciplinary notes in free hand. *Sometimes illegible and incomplete*. (62.5 %)
Page8	For recording multidisciplinary notes in free hand. *Sometimes illegible and incomplete* (62.5 %).
Page 9	The top part is for recording results such as x- rays and any other treatment given whilst the rest of that page which amounts to just over half a page, covers critical factors concerning the safeguarding of children. *Risk factors were not always recognised* (64 %).
Page 10	For the recording of medication. Always completed (100 %).

Figure 6.6 Data from records used locally for information sharing.

Nine significant statements originated from the analysis of records (discussed in Chapter 7, examples in Chapter 5).

6.3 Findings from focus groups' discussions stages two and three of the study

Participants from both the LOCP group and the A&E staff were involved in this study and their status or roles in their services identified (**Tables 5.2 and 5.3.)** Observation of the positions in which participants sat during the focus group discussions are illustrated below in **Figures 6.7** and **6.8**, and physically indicate an implicit shared understanding of seniority within each group. This is also evident to an extent in their contributions to the discussion in both groups. The sequence in which participants spoke is numbered from first to twelfth. Please note that the group discussions were an interactive process, but some referred to others within the discussion. Although some participants spoke for a longer period than others, none spoke continuously.

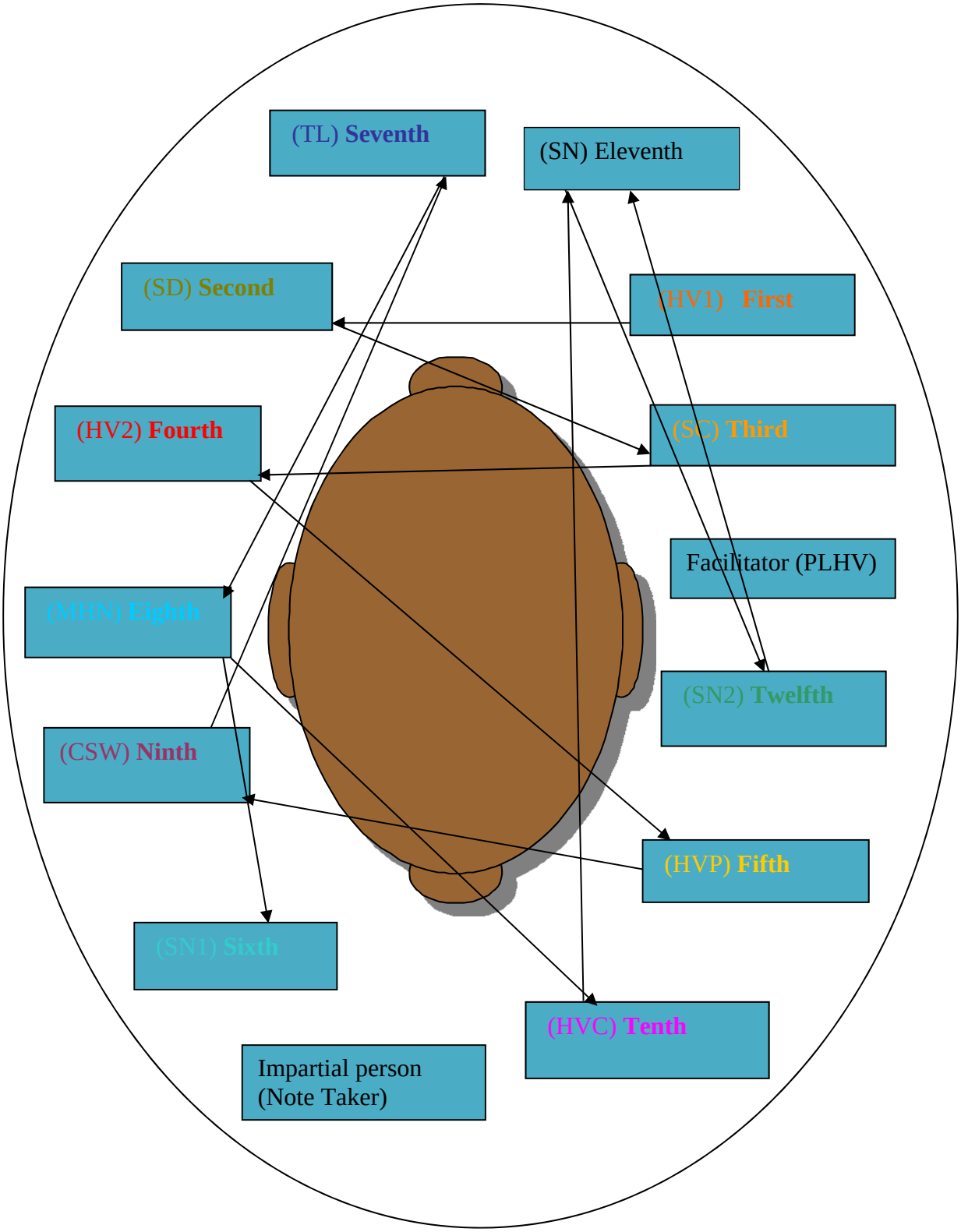


Figure 6.7 Stage two - Participants of the LOCP group.
Arrows in diagram demonstrate to whom each participant spoke.

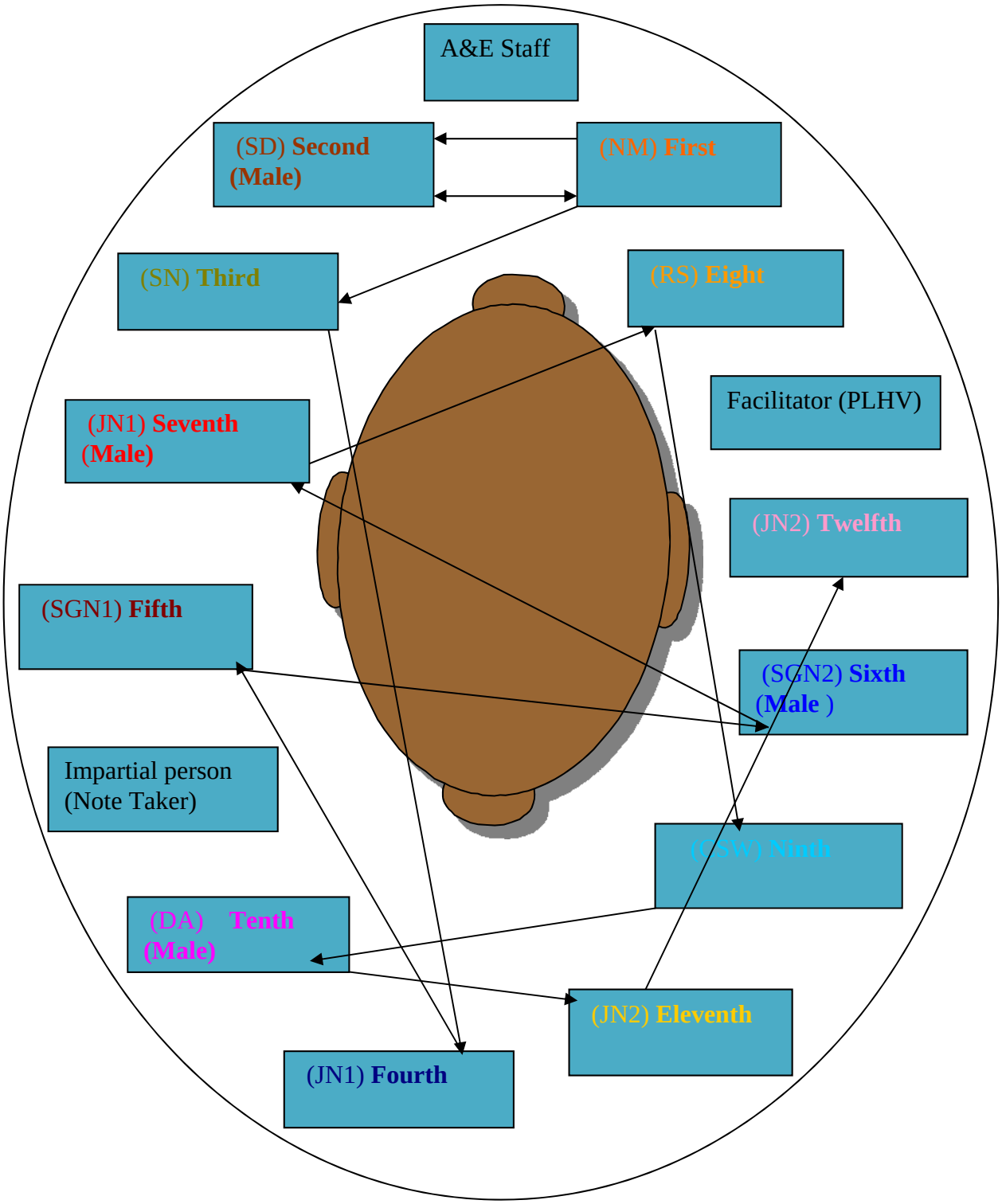


Figure 6.8 Stage three - Participants from A&E.
Arrows in diagram demonstrate to whom each participant spoke.

6.3.1 *Stage two - Non-A&E staff*

These participants identified the importance of effective communication. The time and order they spoke are illustrated below in **Figure 6.9** and **Table 6.2**. The purpose of these diagrams is to illustrate that both the time and order participants spoke is relevant to this study, because the samples indicate that there is a connection between the patterns of behaviour and communication associated with status and power which could impact on effective documentation. **In Figure 6.9** each colour represents in minutes how long each participant spoke during the focus group discussion. In **Table 6.2** because the focus group discussion was an interactive process each colour demonstrates the order and time in minutes spent speaking by each participant. Primarily, the participants considered that A&E records were a good tool for communication. However, effective communication relates to documentation. They also highlighted the fact that written documentation should incorporate a comprehensive history, since the information could alert a clinician to possible risk factors that are likely to affect the welfare of a child. They emphasised the fact that any shortcomings in documentation may create multiple difficulties for another agency or professional to which the child is referred, as inaccurate accounts may lead to failure to safeguard a child. The following quotes are an illustration of the participants' response:

"I am not only expressing my own views but also those of my colleagues. We all feel that they are a good thing but there are times when we have difficulties to understand the illegible hand writing" (Health Visitor).

"Forms not received, page at back – not completed – which would be most appropriate to complete, e.g. box relating to concerns. I have spoken to the other G.P's most reported do not receive these records. All they receive is a brief letter which does not give enough information. We feel it would be helpful to receive these records. It would be helpful if the page at the back is completed with the most appropriate information e.g. box relating to concerns. Most reports mainly only seen from the front page, not seen page at the back" (GP).

Twelve significant statements originated from the focus group stage two – Non - A&E staff.

6.3.2 *Stage three - A&E staff*

These participants focused their attention on the issue of incomplete documentation. The time and order they spoke are illustrated below in **Figure 6.10** and **Table 6.3** (explained above). **In Figure 6.10** each colour represents in minutes how long each participant spoke during the focus group discussion. In **Table 6.3** because the focus group discussion was an interactive process each colour demonstrates the order and time in minutes spent speaking by each participant. They were concerned, that existing records did not provide a format that enabled staff to record information comprehensively, and about issues regarding training. The NSF (DH and DfES, 2004) for children and the Working Together to Safeguard Children (HM Government, 2010) promote good documentation as an essential underpinning to good child protection practice. Below are selected illustrative quotes, they are intended to help the reader understand the way in which the participants answered the research question. Staff recognise shortfalls in recording:

"I think we need a little bit more information on the front of the records a tick box would help staff to remember what needs to be included, as S- was saying previously a tick box would help us to remember what is needed. We should I think have the GP and health visitor down as well things like that. The tick box thing may be would help staff. A tick box would help staff. This could be used for adult as well as children" (Senior Nurse - A&E*).*

"A lot of needs for retraining. We need to check information each time they check in. Check the address, as who they are and not just go on the previous screen and just click yes" (Senior Nurse- A&E).

Twelve significant statements originated from the focus group stage three- A&E staff

6.3.3 *Non-verbal communication from non A&E and A&E staff*

In this study non-verbal communication represented rather a fruitful area for the research, since it established that what was being verbalised by some participants

was different to what they were communicating through body language. Emotions, gestures, and body language were the three main categories identified which reflected the involvement or detachment of participants within the setting being observed. The categories were constructed as such so that certain types of behaviour were classified as one, for example, the manner in which the participant spoke, their tone, loudness and continuity of speech were classified as emotions. These categories are defined below based on theoretical perspective of the nature of social interaction:

- Emotions – feelings expressed;
- Gestures – intentional in terms of desire to communicate;
- Body language – the way we hold our bodies to punctuate or accentuate certain things we say.

Time Series		Participants	Represents time
Time spoken			
	How long		
14	5 mins	1 HV1	
14.05	10 mins	2 SD	
14.15	5 mins	3 SC	
14.2	4 mins	4 HVC	
14.24	3 mins	5 HVP	
14.27	3 mins	6 SN1	
14.3	7 mins	7 TL	
14.37	3 mins	8 MHN	
14.4	3 mins	9 CSW	
14.43	3 mins	10 HVC	
14.46	6 mins	11 SN	
14.52	3 mins	12 SN2	

Figure 6.9 LOCP- Time participants spoke

Participants	Time series	Colours representing time spoken
	How Long	
1 HV	5 mins	
2 SD	10 mins	
3 SC	5 mins	
4 HV2	4 mins	
5 HVP	3 mins	
SN1	3 mins	
7 TL	7 mins	
8 MHN	3 mins	
9 CSW	3 mins	
10 HVC	3 mins	
11 SN	6 mins	
12 SN2	3 mins	

Table 6.2 LOCP- Times and order participants spoke

Time series		Participants	Represents time
Time spoken			
	How long		
11	13 mins	1 NM	
11.13	11 mins	2 SD	
11.24	5 mins	3 SN	
11.29	6 mins	4 SN3	
11.35	4 mins	5 SN1	
11.39	5 mins	6 SN2	
11.44	4 mins	7 JN1	
11.48	2 mins	8 RS	
11.5	2 mins	9 CSW	
11.52	2 mins	10 DA	
11.54	3 mins	11 JN2	
11.57	3mins	12 JN3	

Figure 6.10 A&E- Time participants spoke

Participants	Time Series	Colours representing time spoken
	How Long	
1 NM	13 mins	
2 SD	11 mins	
3 SN	4 mins	
4 JN1	5 mins	
5 SGN2	4 mins	
6 SGN2	5 mins	
7 JN1	4 mins	
8 RS	2 mins	
9 CSW	2 mins	
10 DA	2 mins	
11 JN2	3 mins	
JN2	3 mins	

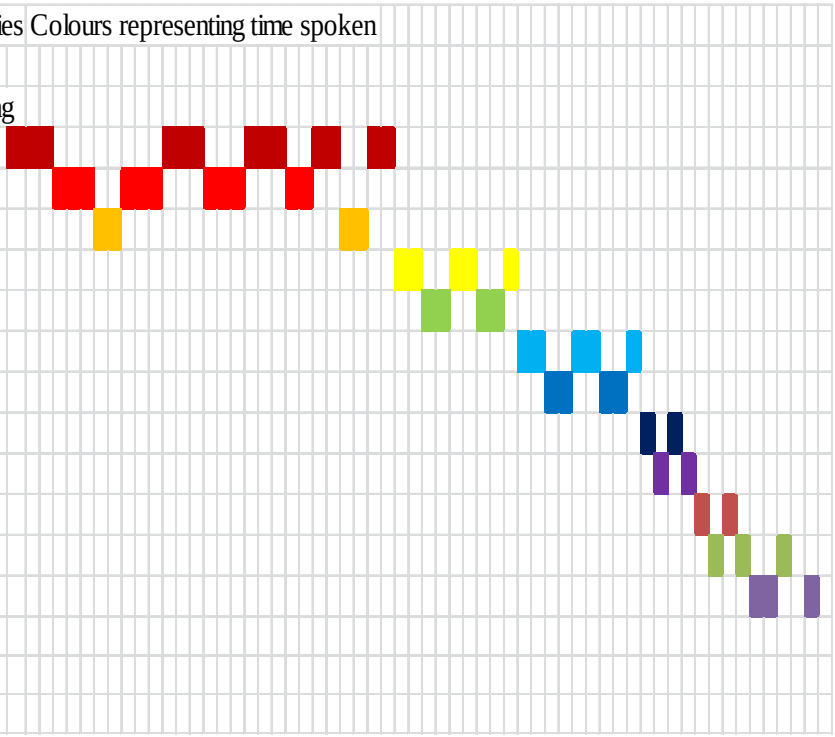


Table 6.3 Times and order A&E participants spoke

6.4 Observational notes and dynamics from focus group discussions

6.4.1 *Non-A & E staff*

They appeared to have adopted an appropriate attitude which did not display excessive emotion. A health visitor was the first to speak. She appeared to have been touched by what was said prior to the focus group discussion by her colleagues, because she said:

*I thought it was important to have a discussion with the other health visitors at my clinic about this topic after I received the participants' information leaflet and had decided to participate in the focus group. So I am not only expressing my own views but also those of my colleagues. We all feel that they are a good thing but there are times when we have difficulties to understand the illegible hand writing. They are useful but they do not include any Action Plan/Care Plan"(*Health Visitor).

She also appeared passionate and openly expressed what other participants may have been feeling and experiencing. I observed that her action became a valuable

experience for the entire group. It assisted them in examining the relevance of what was being said about the records. I also witnessed the increasing sense of cohesiveness within the group as participants shared their experiences.

The safeguarding doctor, who was also a G.P, may have been wearing two hats on this occasion and as the late arriving member, she entered the room dramatically, offered no explanation even though the group discussion had been arranged well in advance, but this may have been a power play. She also sought to dominate the discussion by interrupting other participants and spoke for the longest time (illustrated in **Figure 6.9**). She may have been passionate and/or wanted to demonstrate her power and control over the group by her actions. Nevertheless, even though they responded with disagreement and alternative points of view, members were generally receptive to each other's comments.

6.4.2 *A&E staff*

I noted that eye contact was exchanged within the group. This appeared to have an effect on the behaviour of the group and the interaction became regulated. As I continued to observe the group's interaction, a senior nurse spoke first (illustrated in **Figure 6.10**). Her manner was forceful; she spoke loudly in rapid bursts. She sat forward in her chair, her gestures were large and expansive and she openly exerted her authority. This appeared to have an effect on some of the other participants. She also used tactical communication within the group. She did not appear to have a negotiated and shared strategy. Therefore, her approach gave the impression she may have been reliant on control. Her controlling style of interaction communicated power and professional status and appeared to spend too little time listening to the other participants. I noticed that a few members frequently looked at her, as she gestured to staff by making eye contact. One interpretation of this observation was that these particular members may have been intimidated and were seeking her approval.

The paediatrician, spoke at conversational level, but sat almost motionless in his chair. He did not make any gestures, but as I listened to what he said, it became clear that he was being defensive about the quality of records and documentation.

A legitimate reason for this may have been that he was concerned about the damage to the department because he said:

"Something that concerns me on the front of the records is that we have accompanied by and the usual, we need to know who that person is. A name and the relationship to the child as well. Making sure that the person who is with the child especially if they have another name has the responsibility to authorise that treatment. We need to know who this person is before we treat"(Paediatrician).

One of the junior nurses spoke very softly and paused frequently. According to Kasl and Mahl (1965) this typically indicates anxiety. She sat back in her chair, almost withdrawing from others in the group, in an effort not to be too noticeable. A great deal of what she said was in agreement with everyone else. Although she appeared anxious, she was ready to please and eager to gain acceptance.

The level of participation from a senior nurse was low. She spoke infrequently and only when questions were directed at her. When requests for more generalised answers to questions were made she did not respond. She also appeared bored and disinterested. However, she showed a high level of responsiveness and alertness when the group discussion was nearing conclusion. When a clinical support worker spoke, she lowered her voice, and averted her gaze downwards. This gave the impression that she either lacked confidence in her suggestions, or was fearful of others response to them.

6.4.3 *Group dynamics -Non-A & E staff and A&E staff*

During both focus group discussions, I observe the following - passion, silence, awkwardness, impatience, anxiety, issues regarding trust and mistrust, cautious and guarded conversations. I also felt they were testing each other and me, fulfilling the need to feel important. These energetic dynamics may have emanated from the individuals themselves or were formed by group dynamics, based upon the roles assumed by the individuals within the group. Roles can be obligatory patterns of behaviour within the healthcare system; therefore status achieved allows the use of power. Consequently, the perception of power varied according to each individual's role; including the challenges of management and leadership. Other

issues that appeared to be controlling concerned inter-relationships such as boundaries, roles, configurations, structure and organisational design, work culture and group process. The impression formed was that the complexity of the behavioural dynamics created some anxiety, which made it difficult for some participants to engage with the group discussion on an equal level.

Having had the benefit of closely witnessing the interaction of the two groups, I felt that the energy of some individuals within the group discussions forced the direction of the group's focus and dynamics. Individuals, who come together as a group, bring their individual heritage, experiences, knowledge and awareness, together with fears and insecurities (Bion, 1992; Salant and Dillman, 1994; Mays and Pope, 1996; Crabtree and Miller, 1999).

One participant from the A&E group appeared to focus on covert aspects and attempted to manipulate or control the energy within the group. Status and rank was used in an attempt to include some and exclude other participants. It was also interpreted that flight reactions were used as a defence mechanism in the discussion with other participants. Some individuals in the group tried to cope with this discomfort by appearing to use unconscious projection for attention and reassurance. Consequently, this created a need to be absorbed and join a powerful union. Thereby, surrendering themselves to passive participation.

One participant, who spoke softly and paused frequently, appeared uncomfortable, as if trying to escape into her own comfortable world. It was also fascinating to watch, how another participant, who was a senior member of the team, used this behaviour in an attempt to remove themselves from the process. This behaviour could be interpreted as participants attempting to distance themselves from the phenomenon.

There was also evidence of boredom being a defence mechanism. This could be interpreted as not interested, or they may have been feeling anxious. Therefore they were disengaging on the unconscious and dynamic level. While boredom may feel like a passive reaction, psychologists suggest that it is a more dynamic and active process than it seems. Fubini (1988, p.318-319) describes it thus: "Boredom is a

sign of something carefully avoided, often unexpressed anger which has turned into a feeling of isolation, sometimes to such an extent that no real form of communication can take place." Although I am aware that group process can lead to an individual sense of cooperation and coordination, I am of the opinion that if the senior members of the team had not been present during the focus group discussions, the entire set of group dynamics may have taken another direction.

6.4.4 *Differences and similarities*

Due to the diversity of the participants in both focus groups, it became clear that a level of apprehension was present, particularly in the A&E group. This manifested itself in different types of defensive behaviour. Although the doctor in the LOCP group appeared dominant, it is possible that she may have retained a stereotyped image of the nurse as one who is to carry out her instructions. Thus in this situation she may have seen herself as the leader. Nevertheless, as there were nurse specialists in this group, who were knowledgeable within their respected areas of work, they participated in the group discussion accordingly, and did not appear to be inhibited. Therefore, it was evident that the work of some nurses and doctors were now more integrated.

On the other hand, although the nurses in A&E appear to act independently in carrying out their tasks, within this focus group discussion it was evident that there might have been an assumption that the doctor was the leader. Traditionally between professions, the relationship between doctors and nurses has been one of doctors delegating specific tasks to nurses and directing nurses in their different activities, whilst nurses have been responsible for carrying out these instructions. Also, a senior nurse spoke for a long time,[39] and perhaps gave an indication of how things were done in a real situation. Her communication through eye contact appeared to have significantly influenced the interaction of the other participants. Her controlling style of interaction communicated power and professional status. Therefore, some participants may have considered that the status of a senior nurse equates to that of a traditional matron, who was once the most senior nurse in a hospital and was responsible for all the nurses and domestic staff, overseeing all

[39] Illustrated in **Figure 6.10**

patient care, and was often seen as a fearsome administrator who commanded huge respect. It is also possible that some staff still perceive that the traditional role boundaries are not to be crossed. As a result, some participants appeared apprehensive.

6.4.5 *Gender differences*

They are an important cultural issue in institutional practices, because it may compound communication difficulties (Connell, 1978; Giddens, 2009). Although it is changing, in healthcare the majority of medical staff are males and the majority of nursing staff are females (Giddens, 2009; ICHSC, 2011). In this process, unsubstantiated assumptions suggest, that existing gender differences in healthcare reflect the wider inequalities in power and control. For although there are some matriarchs, there are not many known societies in which females as a whole enjoy a greater economic and political power than men (Connell, 1978; Giddens, 2009; Banyard, 2010; Fine, 2011). Sociologists refer to this pattern of male dominance as patriarchy. According to Doyal (1995) the sphere of healthcare gender differences focuses on patriarchy, therefore gender based attitudes and values may account for differences in behaviour.

Although in the LOCP group all participants were female, in the A&E group there were four male members. It was observed that the four male participants reflected dominant gender roles within society. They spoke for a total of 22 minutes and also appeared more independent and more focused on solutions. By comparison, the female participants liked to discuss problems and needed more approval from the other participants. There is an indication here that gender differences in A&E may be influencing how and what is communicated in written documentation.

From the two groups observed interacting there were differences in behaviour. The LOCP focus group discussion was much more collaborative and related more to integrated working. Whilst in contrast, the A&E focus group discussion was more consistent to the style of working on a hospital ward. In the LOCP group, although the issue of power was present, it appeared to be more evenly distributed and was not explicitly obvious. In the A&E group, however, the three main people who were responsible for the standards of documentation were the first to speak. They

identified themselves as being two senior nurses, and a paediatrician. It was evident in this group that behaviour was controlled by higher status and power. Consequently, communication was extremely controlled. Thus, the two different contexts illustrated different types of interactions which could influence the effectiveness of written documentation. It was also evident that the LOCP group viewed poor documentation as a serious barrier to safeguarding children, whilst the A&E staff did not raise this issue to the same extent. Based on observational notes there were two significant statements.

6.5 Additional findings

In May 2010 a collaborative audit was completed over 3 days by the Acute Hospital Trust, when 100 child records were reviewed. The audit identified four main areas where improvement in practice was required:

- Process

There were issues regarding accuracy, completeness and clarity.

- Documentation

Difficulties in understanding what is written in the records as handwriting was often illegible.

- Communications

Due to inaccurate or incomplete documentation, concerns were identified regarding communication between departments.

- Training

As a result of the above audit a clear need for training was established. This is important as it indicates that no significant progress has so far been made.

6.6 Conclusion

The study has found that child records are a good tool for communication. However, the findings highlight significant issues regarding the content and accuracy of the records and indicate that there is poor quality in recording and sharing of pertinent information to other colleagues. Risk factors are not always recognised and the records are insufficiently child focussed. The findings of this research are a clear demonstration that poor documentation and information sharing can be a serious barrier to child protection. It also provides important evidence of a controlling style interaction, communicating that power authority and

status is favoured. Therefore, these issues influence and appear to impede the ability of professionals in a health and social environment, to fulfil their roles relating to the protection of children.

The central themes that were reflected in all three stages of the study are communication and power, staff passivity with the process of assessment, recording/record creation, non-adoptive approaches to hospital management and imbalance in professional knowledge. The following chapter analyses the findings presented here in order to grasp the significance of the human element on documentation and information sharing.

Chapter 7 Data Analysis

Introduction

This chapter presents the data analysis of the study. The discourse of the use of child records as a means of improving child protection is being examined to acquire a sense of the social construct people place on documentation and information sharing. The degree and factors influencing the appropriate recording, selection, and communication of information to other contemporaries could contribute to the conceptual learning of both myself and colleagues. Thus the 35 significant statements (discussed earlier) relating to staff perception and value of documentation as it unfolded were analysed. The following themes were identified, they are: communication and power; staff passivity-disengagement with the process of assessment; recording, which includes record production; non-adoptive/adoptive approaches to hospital management; and imbalance in professional knowledge (training). These elements led to formulated meanings and five themes emerged in frequency and prevalence which described staff value and perception of A&E child records. Illustrations are provided to explain how codes and significant statements emerged from the data (outline of thematic interpretation is illustrated in **Figure 7.1** below).

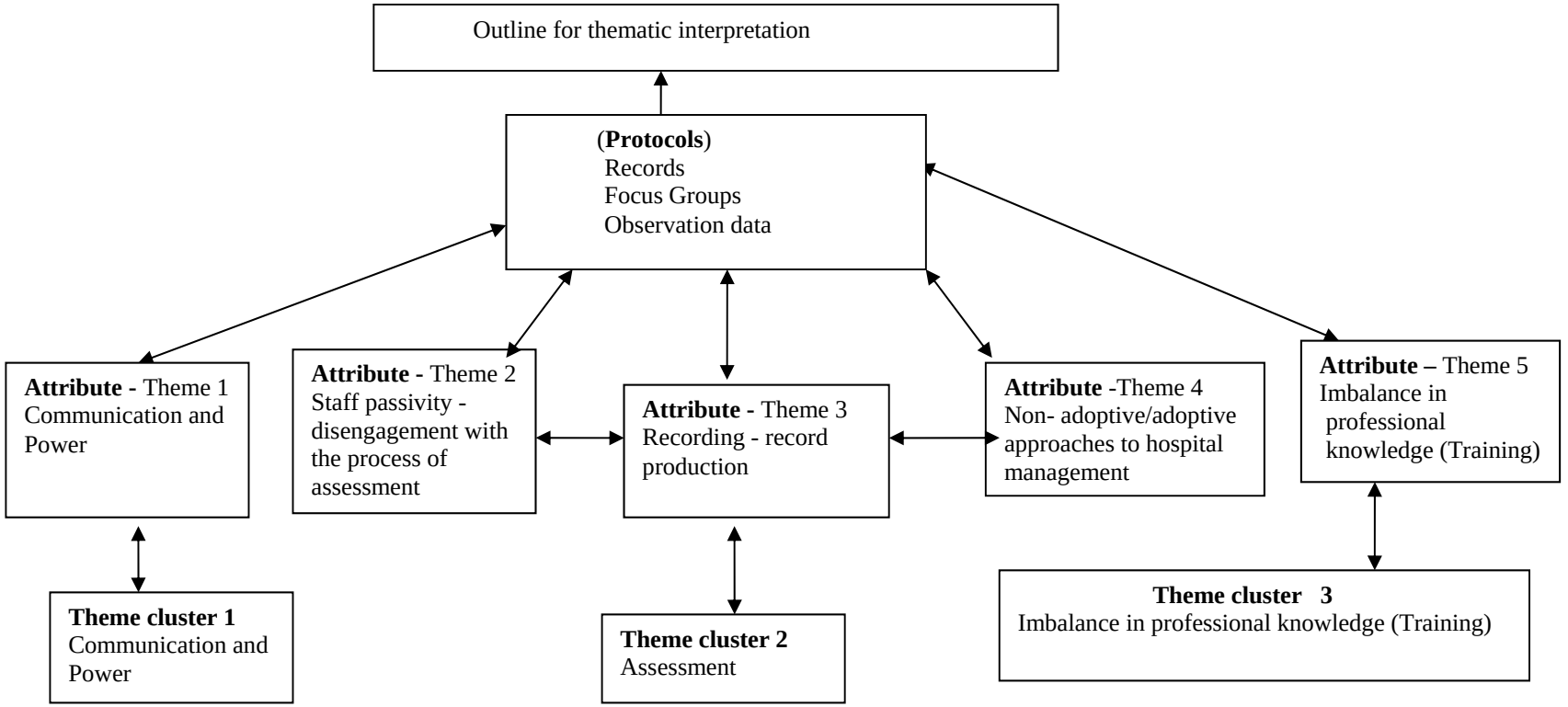
7.1 Researcher's intuitive interpretation/ explanation

Intuition played a very significant role in this study. Therefore, in writing the interpretations of the significant statements and formulated meanings, I have predominantly drawn on my many years of experience and knowledge as a clinician. I have also used my research experience and actual scrutiny of practice in my explanation of the account. This implies that the correct answers can be obtained through conscious reasoning. Nonetheless, some acknowledgement must be made that in my interpretation there are issues potentially relating to bias (see Chapter 5).

7.1.1 *Hospital process*

Within the hospital structure, the process relating to health records management, including the creation of records, is subject to numerous constraints, such as NHS guidance, legislation, codes, regulations and standards. The complexities and

Figure 7.1 Outline of thematic interpretation



consequences of these documents require considerable understanding. Within this environment the A&E staff were observed to relate more easily to the basis of the social structure. The origins of this preference are grounded in and is socially controlled by its institutionalised action arising from the history of documentation. I am here attempting to improve written documentation by highlighting the relevant issues derived from the responses of the participants. This is achieved by extracting significant statements from the data. The current state of A&E record keeping is illustrated in **Figure 7.2** below.

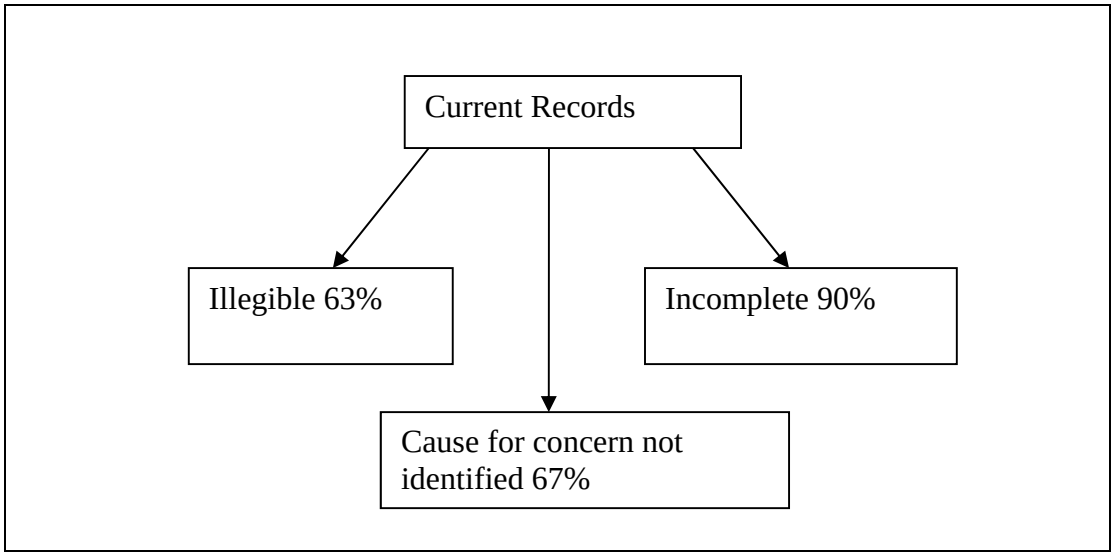


Figure 7.2 Current record keeping

7.2 Significant statements and formulated meanings

The significant statements and formulated meanings (see Chapter 5 for examples) pertaining to the phenomenon being studied were extracted from each transcript/protocol and excerpts are provided below. The quotes selected below for the purpose of analysis are intended to help the reader understand the way in which the participants answered the question. The results were then organised around themes, these were unifying ideas and recurrent elements developed during the research as this strategy best accomplishes the purpose of the study (Kruger, 1997). In order for the significant statements to be understood in a meaningful manner, the significant statements are broken down into sections, the underlying meanings of each section of significant statements, called formulated meanings, were given the same number as the group of significant statements from which they derived. For example: Significant statements - 1,2,3,4. Formulated meanings - 1,2,3,4. The data

revealed five overarching themes which serve to illustrate that the participants' descriptions have significance for colleagues in both health and social environments. Discussion of the five overarching themes identified earlier now follows (development of themes and theme clusters are illustrated in data analysis 5.20.1- 5.20.3 - Chapter 5).

7.2.1 *Theme one - Communication and Power.*

In a health and social environment colleagues need to communicate effectively in order to safeguard children (DfES, 2004a; HM Government, 2010). One feature of how communication works in social interactions is its relationship with instrumental power (imposed by the organisation, by its policies and procedures). It is also generally recognised that roles are a required model of conduct within the healthcare system; therefore status allows the use of power. The work of Foucault (1977), presents a notion of power in his examination of how subjectivities are managed through disciplinary practices. He argues that although a sense of professional competence is part of a self-discipline that confirms identity as a valuable worker, it also reproduces the power relationship that exploits the worker. He suggests that where earlier societies used brute force to influence populations, modern society has developed a more indirect and effective system of social control. Foucault (1977) accords particular importance to places such as hospitals, which he argues function as privileged sites for the disciplining of modern subjects, designed for the production of well-behaved subjects who learn to monitor and regulate their behaviour in accordance with hegemonic standards. He wrote "power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault, 1980, p.30).

In this group shown below there were nine significant statements (discussed earlier) which were subdivided into three sections:

Section 1-Significant statements - 1,2,3 and 4. Formulated meanings 1,2,3 and 4.
Section 2- Significant statements - 5,6 and 7. Formulated meanings 5,6 and7.
Section 3- Significant statements - 8 and 9. Formulated meanings 8 and 9.

7.2.1.1 Section 1 - *Significant statements 1,2,3,4*

1"*Sometimes the doctors* [A&E doctors] *writing is very hard to read and we need to be able to do this accurately in order to follow up on the information. The other thing that causes problems at times is the abbreviations used, please could you request that these be avoided*". (SN1 – LOCP focus group).

2."*I am not only expressing my own views but also those of my colleagues. We all feel that they are a good thing but there are times when we have difficulties to understand the illegible hand writing"*(HV1- LOCP focus group).

3."*The information is not clearly documented, and it is not always clear who is present with child in A&E. For example if teenagers, age of friend or indicate who accompanies them"* (TL-LOCP focus group).

4."*Forms not received, page at back – not completed – which would be most appropriate to complete, e.g. box relating to concerns. I have spoken to the other G.P's most reported do not receive these records. All they receive is a brief letter which does not give enough information. We feel it would be helpful to receive these records. It would be helpful if the page at the back is completed with the most appropriate information e.g. box relating to concerns. Most reports mainly only seen from the front page, not seen page at the back"* (SD- LOCP focus group).

7.2.1.2 Section 1 - *Formulated meanings 1,2,3 and 4*

Problems in understanding the importance of effective written communication appear to be directed on the primary person responsible for the initial generation of records, the A&E doctor (statement 1), but their status makes this problem difficult to tackle. There appears little acknowledgement of the function of records when medical abbreviations or A&E jargon are used.

Written records have the potential to be a good tool for communication and this information is valued if complete. Nevertheless, in A&E due to status, process and structure, issues concerning communication and power impact on the behaviour of staff. The comments in statements 1 to 3 imply that where a full and

comprehensible history is important, the needs of other readers are not always taken into consideration. It is evident that social constructed meanings needed for recording are not common to all parties. Poor handwriting is inaccessible to other colleagues. The remarks suggest that even though the originator may understand what has been written, difficulties may still arise when other professionals are involved in the information sharing process. A major difficulty may be created in obtaining the appropriate information upon which to make an informed decision, consequently the required assessment may not be possible. It is understood from current record keeping standards that practitioners must ensure that any entries they make in someone's paper records are clearly and legibly signed, dated and timed. Thus, the responsibility of the staff in A&E should be to ensure that the written wording in the documentation does not obscure or distort the meaning, as this could mean that records remain inaccurate. When this occurs, it is likely for misinterpretation to arise, which may have a direct effect on the use of the records, thereby causing a failure of the consultation process, and the potential for a child to remain unprotected, or subjected to inappropriate attention.

Illegible handwriting and the use of abbreviations in statements 1 and 3 gives an indication that staff may be experiencing time pressures that may be causing work related stress. The term work related stress means the process that arises where work demands of various types and combinations exceed the A&E staff’s capacity and capability to cope. For example, increase attendances and low levels of staffing in such a clinically challenging area may affect the part an individual plays in recording information appropriately. Furthermore, it is generally recognised that staffing issues in most A&E departments are real and time is limited, basically this means that there could be a shortage of time to do a particular task. A further factor relating to communication and power that may influence documentation is the issue of A&E targets (instrumental power), and the fact that the government wants the majority of patients to be assessed, treated, discharged or admitted within four hours which could in some instances compromise the care of a child. This is because documenting an assessment may be perceived to be a required action for processing a patient, thus thinking in a one dimensional track of only treating the

injury of the child, rather than considering communicating with a colleague to assist in safeguarding children.

Statements 1, 2 and 4 also show that if documentation was made clear to colleagues in both a health and social environment it may enhance and promote the welfare of a child. Effective communication relates to helpful documentation; therefore, they are highlighting the fact that written documentation should incorporate a detailed history. This identifies with the key tool in safeguarding the health and wellbeing of a child since the information could alert a clinician to possible risk factors that are likely to affect their welfare. The information obtained, together with clinical examination, enables the practitioner to form a diagnosis and treatment plan. In addition these excerpts are signifying that there is an issue here relating to social control thus key skills and knowledge are required for taking a full history. So by achieving the required skills, the practitioner's ability to interpret complex clinical information, children's observations and findings will enhance, safeguard and promote the welfare of the child.

Perhaps, what has been expressed in action and practice may reflect the everyday practice within the clinical area of A&E. It implies that no one person is responsible for ensuring that the evaluation of quality care is maintained. Therefore, either quality assurance activities are not being adhered to, or quality assurance is monitored by groups of professionals in isolation from the rest of their professional colleagues. As a result, staff remain unsupervised. This has a powerful influence on the value staff place on child records, since what is not being measured is how the documentation by one professional impacts upon the care given to a child by another. The wellbeing of the child should be the primary concern; given that this tenet is enshrined within the different codes of each of the United Kingdom's healthcare regulators. Nevertheless, since a clear hierarchal power relationship is present, staff may find it difficult to elicit needed support from colleagues who are more powerful than themselves. It is therefore essential that practitioners have adequate competence and skills in ensuring that decisions are taken in order to ensure that the care of a child is not compromised by ineffective documentation. The findings and contextually embedded expertise that

emerged from experience indicate that practitioners without the necessary knowledge and support are less likely to place value on the records than practitioners who are knowledgeable and feel supported.

7.2.1.3 *Section 2 - Significant statements 5,6 and 7*

5."*Queries within a timescale or trigger after set number of attendances - Computer generated e.g. King's standard information included on form of attendance"* (SGN2-A&E focus group).

6."*Number of attendances – i.e. if over 4 there should be automatic referral to safeguarding team*" (SN-LOCP focus group).

7."*Health Visitor will normally contact family to offer support – parents are not always aware that information has been shared with the Health Visitor*" (HVP - LOCP focus group).

7.2.1.4 *Section 2 - Formulated meanings 5,6 and 7*

The information above in statement 5 was interpreted to mean that some staff had no comprehensive understanding of what was happening to them as they carried out their everyday tasks and responsibilities. Thus, this analysis of their limited range of reflective vision appears to be a central element in the documentation process. Although this is not stated explicitly, it is indicated and perhaps implies, that the range of critical thinking is limited. This may be explicable when a serious child protection situation is uncovered, for there is considerable consternation regarding documentation and information sharing. What tends to get forgotten is the previous history of what has happened prior to the disclosure of the incident.

Following investigation of each serious child protection case, it is clear that no lesson from history is being understood. Therefore, the behaviour of the A&E staff are regulated in accordance with procedures and the dominated influence associated with communication and power. This could possibly be related to the influence of routine or everyday assessment in which the child presenting to A&E may be seen as a succession of different categories of cases, rather than as a person. As a result in an A&E environment the individual's thinking may be inhibited.

Illustrations from the findings in this study highlight the fact that the communication pathways need to be improved because they appear ambiguous. Part of the problem may be that staff are fully occupied in the process (das Mann) rather than making authentic decisions for themselves in each case (Heidegger 1962). They need to be able to identify the signs of what is relevant when caring for the child, since the child's safety and welfare should always be the main focus of written documentation. However, it appears that a lack of emphasis on the needs of the child ultimately affects the decision making process. This is because the staff appear to be giving and receiving different messages with regards to what should, or should not, be referred automatically to the safeguarding team (statement 6). Thus, this implies that they may perceive the issue of documentation and information sharing as if it was of no interest or concern to them. As a result, this could eventually cause difficulties to remain in the recording of valuable information, which may possibly have an impact on making the correct assessment of the child's needs.

The above extracts in statements 6 and 7 also suggest that staff do not always concentrate on the process of communicating appropriately. This indicates that little attention is given to the issue of the association of social interactions and its relationship with policies and procedures, therefore the staff's ability to achieve a greater role in the decision making process is impeded. Thus, tension exists between practitioners as to whether they are committed to integrated and anticipatory care. This is illustrated in their relationships with others and is clearly where the crucial issues regarding documentation exist. Hence, this suggests that because of their poor relationships and social interaction they are not communicating effectively. Subsequently, they are intimating that written documentation is not considered an integral element of communication or an important part of the procedure. They also appear to be indicating that, because of their lack of communicating skills, they are not committing themselves to being personally involved in the process.

7.2.1.5 *Section 3 - Significant statements 8 and 9*

8. Although the doctor in the LOCP group appeared dominant. These participants did not display excessive emotion (Chapter 6, findings LOCP focus group).

9. Status and rank was used in an attempt to include some and exclude other participants (Chapter 6, findings A&E focus group).

7.2.1.6 *Section 3 - Formulated meanings 8 and 9*

In statements 8 and 9 above which are based on observational notes though the issue of power was present, it appeared as if it was more evenly distributed and was not explicitly obvious in the LOCP group. Nevertheless, the three main people in A&E who were accountable for the standards of child protection documentation and identified themselves as being, a doctor and two senior nurses for safeguarding children, spoke first. From his persona, the doctor gave the impression that he was the most powerful clinician within the child protection area; therefore, it was evident that there might have been an assumption by the participants that the doctor was the leader. This behaviour may have been seen as appropriate, given that the authority structure, which had been institutionalised by the NHS since its foundation, was based upon the entrenched power of the medical profession (Strong and Robinson, 1990). Nonetheless, the senior nurses also communicated power and professional status, their dominant style of interaction, mainly through eye contact, appeared to control the interaction of the other participants considerably, one of the senior nurses also appeared bored and unconcerned. Consequently, the perception of power varied according to each individual's role; this included the challenges of management and leadership.

The impression formed was that the complexity of the behavioural dynamics created some concern, which made it difficult for some participants to engage within the group discussion on an equal level. Due to the diversity of the participants, it became clear that a level of nervousness was present. This was apparent in different types of defensive behaviour, such as, appearing anxious and cautious.

When the evidence from the audited records and the dynamics from the focus groups' discussions are explored, they reveal issues linked to communication and power. The association between the observable attributes of the participants, such as different status in relationships and levels of knowledge, and that the

environment may have a profound effect on the behaviour of staff. Observations suggest that feelings are a fundamental part of the A&E communication process. For that reason, the quality of documentation is likely to improve if the quality of social interactions is enhanced.

It was apparent from the observations of differences and similarities of the participants (Chapter 6), that whilst gender appeared to have little effect on documentation, the A&E doctor, who was male, had quite a profound effect, for he is in a strong position to shape the standard of documentation through the training and information support that he provides. Because of his central role and important position within the field of child protection, as a lead professional, he should provide both practical knowledge and emotional support which may enhance both documentation and the child's care. Thus his attitude towards documentation, as well as the care of children, is seen as critical in shaping effective communication. Nonetheless it was evident that he communicated power and status, hence the other participants appeared to regard this as being perfectly valid. As a result, they remained passive since they were placed in a subordinate position. This influence thereby provides a cue for dominance in the record keeping process and conveyed the message that hierarchy could constrain the interaction and information process. Conflict and frustration also appeared to be evident since an impression was given that some doctors may lack understanding of the role requirements of other professional groups, because different ideologies are endorsed within the documentation process, for example, those of doctors and nurses.

7.2.2 *Theme two – Staff passivity-disengagement with the process of assessment*

It has been identified that systematic recording processes and multi-agencies' procedures over the last three decades have not completely achieved a fully conscientious approach associated with recording appropriate information and communicating data on incidents between agencies (Laming, 2003, 2009; DfES, 2004a; Munro, 2011). In this group shown below there were 11 significant statements (discussed earlier) which were subdivided into three sections:-

Section 1- Significant statements - 1,2,3,4 and 5. Formulated meanings - 1,2,3,4 and 5.

Section 2- Significant statements – 6,7 and 8. Formulated meanings - 6,7 and 8.
Section 3- Significant statements – 9,10 and 11. Formulated meanings 9,10 and 11.

7.2.2.1 *Section 1- Significant statements - 1,2,3,4 and 5*

1. All the 73 records that were chosen for audit were selected because the PLHV identified a cause for concern. Unfortunately, only 24 of the records indicated that a cause for concern had been identified by the A&E staff (records).

2. The records are sometimes illegible or incomplete (records).

3. In 68 of the 73 cases, the date and time of incident/accident were not recorded (records).

4. Records are sometimes missing for days, weeks and even months (Forge, 2006).

5. The records can also be found in inappropriate places, for example, pigeon holes, cupboards (records).

7.2.2.2 *Section 1 - Formulated meanings - 1,2,3,4 and 5*

This form of reaction in statements 1 to 5 was read to denote that they are irritated; hence they are relying on their knowledge of systems and practice to facilitate the required information. Therefore, they are passive and disengaged with the process of assessment. Their awareness of the layers of complexities of systems and processes are also creating a set of difficult circumstances. In this interpretation, it is the work culture and processes that cause some of the issues relating to staff's value of records and gives an indication of reasons why staff may be passive and disengaged with the process of the assessment of children. It appears that they are not only feeling disheartened, but there is a sense of frustration and dissatisfaction. Perhaps they saw themselves almost to the point where they are no longer fostering active engagement and feel that if they become acquiescent in this situation, remain passive and disengaged, their vulnerability may not be discovered. It is possible that they may also feel that if they remain submissive recipients, uncertainty and danger, which is important for their survival, will be reduced. This carries a hidden

implication, because there may not always be exploration of the truth. Whatever it may appear to be on the surface, the situation is charged with emotions, which exert a powerful and frequently unobserved influence on the individual. There appears to be a great deal occurring behind the scenes; therefore they are experiencing a dilemma. For that reason, their stance suggest that they are no longer engaged in fighting or avoiding another significant child protection case, but are open to learning from other experiences.

The information denotes that this representation is influential, as it has significance for contemporaries in both a health and social environment. Although record keeping policies and procedures concerning documentation are provided by the organisation, it seems that they are not considered valuable to staff. Records placed in inappropriate places are indicative of this. These policies and procedures appear to have become irrelevant and sometimes cast aside. Within the socially constructed everyday world of A&E policies and procedures appear not to be sufficiently significant. This type of feedback points towards the possibility that the process of habits and customs gained, through mutual observations of the way things are done, is possibly being followed. This strategy is, perhaps, used for either diverting responsibility onto others or avoiding blame.

The details above in statements 1 to 5 illustrate that the description given is important, because it has implications for everyone involved. This type of reaction was also interpreted to mean that there is an element of critical judgement which is absent, and reveals issues that are related to staff passivity and disengagement with the process of assessment. There are discrepancies here between the needs of the child, documentation and reasonable judgement. This perhaps implies that the ways of thinking are deeply interwoven into the framework of understanding. In turn, it is influenced by habits and expectations that constitute the frame of reference, and gives an indication that the whole concept is oriented towards the way in which A&E staff interpret their experiences. The issues here concern the basic assumption of critical thinking. Although it is not obviously stated, it is being interpreted that critical thinking has not been attached to the importance of learning from experiences. Hence, it is difficult to distance oneself from the perception that a person whose critical awareness is compromised will not be a less competent

practitioner. When the information which has been provided by observing the records is examined, it illustrates staff passivity-disengagement with the process of assessment and the value staff place on A&E child records. Far from providing child records through which colleagues within a health and social environment can share information effectively, the data indicates that there are shortcomings.

7.2.2.3 *Section 2 - Significant statements - 6,7 and 8*

6. *"They are useful but they do not include no action plan/care plan"* (HV2- LOCP focus group).

7.*"I think we need a little bit more information on the front of the records a tick box would help staff to remember what needs to be included, as S- was saying previously a tick box would help us to remember what is needed. We should I think have the GP and health visitor down as well things like that. The tick box thing may be would help staff. A tick box would help staff. This could be used for adult as well as children"* (NM - A&E focus group)

8.*"I've had one recently where a child came in with a drunk lady. The children lived with the father. She said she had access but it turned out they pop in every now and then. She didn't have formal access. There was nowhere to put this on the card"*. (JN2 - A&E focus group)

7.2.2.4 *Section 2 - Formulated meanings - 6,7 and 8*

The preceding statements 6, 7 and 8 indicate that the way people see things, the way they feel and act could be based on experiences. Documentation would seem to be shaped on their ability to understand the relevance of safeguarding and promoting the welfare of a child. Whatever the above excerpts suggest on the surface, the possibility exists that they are laden with views which exert a powerful and frequently overlooked influence on the person. This type of behaviour was, therefore, interpreted to mean that there is no clearly explicated process or procedure. Therefore, it could be construed that consistency and structure are deficient. In response to the safeguarding of a child, whilst the professional role of the A&E staff as providers of information is acknowledged, perhaps staff are left

feeling that they are in a situation of protecting themselves, hence a sense of inadequacy is being experienced, therefore they remained passive and disengaged.

7.2.2.5 *Section 3- Significant statements – 9,10 and 11*

9. *"We do feel that the person booking the children in should always check the school attended as sometimes this is obviously wrong, for example, a 14 year old with a primary school"*. (HVC- LOCP focus group).

10. *"Do you think it would help if reception staff got the triage nurse to see the child first and write a triage first this would help?"(* RS - A&E focus group).

11. *"The reception just writes unwell child even when the child is blue and black." Do you think we could get this information before they come in rather than the history of child being unwell?"* (DA - A&E focus group).

7.2.2.6 *Section 3 - Formulated meanings 9,10 and 11*

This type of data in statements 10 and 11 was interpreted to indicate that the A&E staff may not be working from clear guidelines or procedures. Therefore, it can be perceived that in such situations everyone fends for themselves. As a result, they are learning what they can and cannot do by trial and error. Additionally, this view indicates that there is a needed to be sensitive and careful when presenting the account. Therefore it was important to be clear on the implications of showing the accounts to individuals who were already experiencing stress.

The illustrations from the participants who asked questions regarding history taking by the receptionist in statements 10 and 11 suggest that the account is significant, as its importance would have implications for practitioners, processes and procedures. It is understood that the concerns expressed here may be related to the generation of the records. It may be considered that the basic level of knowledge used may limit A&E staff's ability to provide appropriate information; therefore, potentially important information may be overlooked, thereby affecting the response of the staff. Instead of feeling confident and competent, they are displaying a sense of uncertainty, inadequacy and even anxiety. This could denote that they are acknowledging their limitations.

7.2.3 *Theme 3- Recording/record creation*

The approaches used can be attributed to a variety of factors within the child protection arena, for example ability and experience. Laming (2003; 2009) argued that identifying those children with the greatest need of protection was a particular issue for A&E departments. He noted an association between some child deaths that have occurred following attendances at A&E, because they were missed at the early stages due to poor record keeping and information sharing. Accordingly correct record keeping should remain first and foremost the responsibility of the A&E staff, given that they are expected to be personally accountable for actions and omissions in their practice. According to the Trust Health Records Policy (2004),[40] all entries will be clear, factual, unemotional, unambiguous and objective. In this group shown below there were five significant statements (discussed earlier) which were subdivided into two sections:-

Section 1- Significant statements - 1,2 and 3. Formulated meanings - 1,2 and 3.
Section 2 - Significant statements – 4 and 5. Formulated meanings – 4 and 5.

7.2.3.1 *Section 1- Significant statements - 1,2 and 3*

1. Records, which do not contain any information, are brought to the attention of practitioners, mainly doctors, but are still not completed for days; when issues regarding content and accuracy are brought to the attention of senior nursing and medical staff, their reactions are mixed. Some are concerned; others dismiss the issue as being trivial (records).

2. Sometimes the records are blood splattered and sometimes dirty (records).

3. The written records reveal that in the majority of cases parents provided the history, even though most of the children were at an age where they were able to provide their own (records).

[40] **Appendix 23**

7.2.3.2 *Section 1- Formulated meanings - 1,2 and 3.*

The above findings in statement 1 infer that the omission of documentation is significant not only for the child, but also for practitioners and the organisation. For after an incident it is difficult for a practitioner to justify why there is no documentation. Consequently, omission raises the question of whether staff are actually carrying out action, but either do not have time or forget to document their findings. More significant, is whether or not they have implemented any action. As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions. For that reason, there is the perception that the goal of A&E staff should be to document information efficiently in order to safeguard and promote the welfare of the child. Current documentation standards require that all pertinent information about a child should be recorded and clearly specified, and that records must be completed as soon as possible after an event has occurred.

Healthcare professionals have a shared set of values, which find their expression in their codes of practice. These values are also reflected in the different codes of each of the United Kingdom's healthcare regulators. So apart from keeping clear and accurate records of the discussions they have, the assessments they make, the treatment and medicines they give and how effective these have been, they should also provide a high standard of practice and care at all times (DfES, 2004a, GMC, 2006; DfES, 2006; NMC, 2009). Hence recording and record creation should represent how staff in A&E value and care for a child. The above message is also advocating that there is a need for connection with other people as an integral part of their personal development. The important concern here is that an impression is given that there may be a dichotomy between value and knowledge. Therefore, experience represents a familiar and functional understanding, for when a child presents to A&E there seems to be a connection to a set of systematically related beliefs and ideas about what is felt to be the essential features of safeguarding a child through record keeping.

The version in statement 2 implies that staff may not see the records as a valuable asset, therefore recording/record creation may appear unimportant. Thus this matter

has clinical significance, because it has the appearance of the way things really are. According to the Management of Health and Safety at Work Regulation 1999 - Regulation 5, the legal responsibility for health and safety rests primarily with the employer. It is their responsibility to ensure the organisation has the necessary management framework to protect the health and safety of their staff and to provide a safe environment. This means that they take an active role in carrying out risk assessments, setting health standards, and developing policies, together with monitoring standards regarding enforcement or compliance where necessary. The observational evidence from the data shows there are areas of activity such as the state of the records which are not dynamic. Thus an impression is given, that for the standards implemented locally which can mitigate the risk of infection; there is reliance on individuals to adhere to the practical process of risk management measures. Viewed from the inside, it may appear rational, but from the outside it may emerge as being irrational. An indication is given in statement 3 that the needs of the child and the required recording/record creation are determined by staff's interpretation and explanation. They may be unresponsive to the needs of the child, because they apply their own professionally based judgement of need and value rather than those of the child. Hence, the course of action taken and the documentation provided could be perceived as being created from their perspective.

From these details, it is assumed that it may be indicative of the staff's competence and/or confidence. Consequently, their ability to ensure that they provide appropriate recording and record creation, solicited by the needs of the child, is inhibited. There is an underlying assumption that not everyone may have a broad understanding of the importance of documentation when carrying out their everyday tasks and responsibilities. Thus, they may not always understand that the characterisation of documentation is an extension of their professional accountability and responsibility.

The illustration given regarding who provides the history in statement 3 is important. For, although concern for the wellbeing of the child may seem obvious; it is possible that there may be other reasons why parents may wish to speak on behalf of the child. The law requires that children under the age of 18 years should

be considered as minors; consequently the staff in A&E act in loco parentis when a child's history is taken. It may be felt that the needs of the child have to be balanced against the needs of the parent fulfilling their parental role; however, this can be stressful for parents and practitioners. Therefore, the legal responsibility can be an additional barrier as protective parental responses can predominate history taking. It could also be argued that children in some societies have less status and therefore less power. Hence, their rights to be treated as individuals can be compromised by paternalistic tendencies to protect them. When a safeguarding issue becomes apparent, but is unexplained, parents may not realise how threatening they appear to the staff when they child is not given the opportunity to speak for itself. Accordingly, it may also be virtually impossible to obtain the required information in order to care for the child, if A&E staff are unwilling or unable to bypass the parent. The reality is that the situation can be made more difficult for professionals to make a correct assessment at a later stage, if appropriate and timely information has not been obtained.

7.2.3.3 *Section 2 - Significant statements – 4 and 5*

4. "*Mental Health Unit - communication of admission scant"* (MHN- LOCP focus group).

5. "*For the few that we receive, they are not clearly documented, cannot distinguish who is taking history or in what order. Information in some instances are unclear, unknown abbreviations are used, writing are sometimes illegible"* (SC- LOCP focus group).

7.2.3.4 *Section 2 - Formulated meanings – 4 and 5*

The data in statements 4 and 5, points to issues regarding content and accuracy of records, important factors in record creation and recording, since they have the potential of impacting on the ability of other professionals to fulfil their roles with regard to safeguarding children. It is possible that in A&E where team care exists, there is a tendency to assume that the documentation may be completed by someone else. Another reason being, it is not uncommon for a child to be seen by different professionals, such as nurses and doctors, during the course of their care

in A&E. Under such circumstances responsibility for the overall care of the child can become diffused. Therefore, no one may take responsibility for the whole child, though each may take responsibility for a different part of the child's care. Moreover, certain failures in record keeping/and or A&E procedures to reflect best evidenced based practice has also been identified, for example, record keeping policies and procedures for safeguarding children. The lack of information about what is recorded in the records could be a major part of the problem. For when this happens, the staff may be unable to assess the needs of a child if someone else's documentation is incomplete. The data is also significant since, in some cases, it is possible that parents may not be accessing GP services appropriately. Therefore, any delay in presentation could be regarded as a failure to meet the child's needs. This view of the situation intimates that if staff are busy and concentrating on other departmental issues, they may feel over stretched and are unlikely to pay attention to such details. Therefore, training might alter current thinking in safeguarding and promoting the welfare of children.

Especially important is the extent to which practitioners are supported and are provided with the correct knowledge, as they may experience difficulties if they do not have the necessary expertise. Consequently, safeguarding children may be difficult for them to deal with, so children are likely to remain unprotected because their needs are not properly evaluated. A number of strategies aimed at avoiding openness and honesty can be identified here. Doctors, nurses and other members of staff may pretend that they have the necessary capability even though they know this not to be the case, and may engage in purely symbolic activities. For example, by not offering information initially in cases where there is no clear documentation, and by providing documentation where the hand writing is illegible (see statement 5). By giving the impression that something useful is being done, these strategies could enable them to divert responsibilities onto others, or status and authority may be demonstrated. Because the difference in the institutional structure and regulatory systems affects the individual's behaviour, this perspective also plays an important role as it draws attention to the power inequalities in the roles of the health care professionals.

It is generally understood that recording and record creation are important, because workers in a health and social environment rely on clinical records as the main source of information about the current status and planned care of a child. For that reason the data from the participants is significant. Laming (2003; 2009) expressed the view that the objective of the A&E staff should be to safeguard and promote the welfare of the child. The fact that the records are illegible, or incomplete, increases the difficulty for another professional to determine the child's needs. Incomplete and/or inaccurate documentation upon which clinical decisions about the welfare of the child are made can lead to their needs not being identified. This can be illustrated by an anecdote: in a child's records it was recorded, vulnerable child. The colleague who wrote this in the records assumed a level of knowledge that was basic to her, but not to other colleagues, with a result that a misunderstanding occurred and the child remained unsafe. This was because the meaning was not shared. So, for effective social interaction to occur, multi-disciplinary care relies on a high level of written communication between team members, which appears to be lacking in this case.

7.2.4 *Theme 4 - Non –adoptive/adoptive approaches to hospital management*

Information sharing is vital to safeguarding and promoting the welfare of children (DfES, 2004a). Because the safeguarding of a child is interdependent on accurate and appropriate documentation, conditions or constraints limit the communication of the required information. In this group shown below there were six significant statements (discussed earlier) which were subdivided into two sections:-

Section 1- Significant statements - 1,2,3 and 4. Formulated meanings - 1,2,3 and 4.
Section 2 - Significant statements – 5 and 6. Formulated meanings - 5 and 6.

7.2.4.1 *Section 1- Significant statements - 1,2,3 and 4*

1. Unfortunately, only 24 of the records out of a total of 73 indicated that the A&E staff identified a cause for concern (records).

2.*"There is a question of prioritising, a child may have a broken arm broken in three places by the father but when listed as a broken arm it will come after anyone having a heart attack"*(SGN1- A&E focus group).

3. *"Something that concerns me on the front of the records is that we have accompanied by and the usual, we need to know who that person is. A name and the relationship to the child as well. Making sure that the person who is with the child especially if they have another name has the responsibility to authorise that treatment. We need to know who this person is before we treat"* (SD- A&E focus group).

4.*"You ask people who they are and where they live but nobody asks the child. You should put the mother and father they live with. Sometimes the mother brings the child in but the child lives with the grandparents. It's something we don't ask the child. Some of them are in foster care but do come in with parents during access"* (SN - A&E focus group).

7.2.4.2 *Section 1- Formulated meanings - 1,2,3 and 4*

The above remarks signify that during the initial definition and recording of history, different levels of understanding may be used to produce records for the care of a child, and reveal non–adoptive/adoptive approaches to hospital management. As a result the response to assess the child's needs correctly may be affected if the member of staff lacks the necessary experience and skills. The above comments confirm that, in order to safeguard a child, one should have a good knowledge base from which to understand the situation and needs of children and to devise plans of action that are appropriate to the circumstances encountered (statements 1 and 2). This assertion demonstrates that the understanding of experiences that are perceived, understood, and communicated by others and how they impact on the behaviour and life situations, both in a positive and negative way, should be obligatory.

The earlier examples in statements 2, 3 and 4 serve to illustrate that real choice for the child may not in all cases be based on relevant information. Thus the possibilities of diagnostic errors may arise, at best these may be a waste of resources, but at worse they create the potential for a child remaining unprotected. The account signifies that there are failures to detect, acknowledge or take action. This breakdown could arise from insufficient time, or belief that other members of

staff knew of the child's history and were taking action. In addition, there are also implications for both the practitioner and practice. For not only is it a fundamental requirement to possess the knowledge and skills that are compatible with the demands of the task, it is important to recognise the limits of one's competence and not to take on tasks unless they can be carried out in a safe and skilled manner.

In statements 2 and 3 strong feelings appear to be expressed and are considered to be justified. The quotes serve to illustrate the unease felt by some colleagues within A&E regarding documentation. There is the belief that this passionate request for the recording of the name and relationship to the child is appropriate. It intimates that they are concerned and are actually trying to be supportive. This account has also been understood to be revealing, thus it is interpreted to mean that it is not just a simple matter of completing the documentation, for it has direct relevance to understanding the significance within the field of child protection. It is therefore implied that, concealed within this disclosure, are hidden factors, for example, the education, knowledge and skills of staff.

In statement 4 it appears that although the child is present, perhaps at times staff do not consider the importance of speaking to them. This denotes that colleagues may not always be providing documentary evidence that is solicited by the child's needs. When this circumstance is examined, it is possible to see that the needs of the child may be influenced by the coping style of the family; consequently the success of such coping and the quality of the relationships within the family may affect the wellbeing of the child. Hence, it implies that each individual is acting in the light of the way the situation appears to them; therefore, they may not feel comfortable in attempting to articulate their practice. It may be that in these situations, which are in a more diffused form, they are acting instinctively. Given that their action could be automatic and non-reflective; it would appear not to be part of a discourse. Hence, this does, and could, indicate that the appropriate knowledge and skills for the purpose of signalling that there is a cause for concern may be deficient.

7.2.4.3 *Section 2 - Significant statements – 5 and 6*

5.*"I think when there are problems there needs to be a quicker way to deal with the records, I always get the feeling that it needs more urgent attention. It always happens out of hours it always happens at weekend , it always happens at nights is there somewhere I can write urgent without writing it about twenty times or whatever"*(JN2- A&E focus group).

6.*"We need some way of getting the old cards. You can only read some of the information on one of the records, which is why we need tick boxes and to write it on the front of the card"*(JN1- A&E focus group) .

7.2.4.4 *Section 2 - Formulated meanings - 5 and 6*

The above responses in statements 5 and 6 suggest that it is possible that they may be struggling to maintain a sense of meaning in what they are doing, thus, feeling fraught and disheartened. Their comments imply that individuals experiencing dilemmas are intimidated by them and are thus displaying fear. This fear may possibly be linked to a sense of inadequacy, which may have been related to other significant experiences within the safeguarding arena. In re-evaluating past actions, it may have been easy for them to forget the context of their experiences, which in turn may have had an effect on their behaviour. Hence, they may be feeling ashamed and demoralised; therefore, inhibiting the kind of reflection that is ultimately required, because they are now seeing clearly what seems unacceptable in an isolated way.

The explanation given in statement 6 also shows a vivid image of some of the constraints encountered from non–adoptive/adoptive approaches to hospital management when a child may have attended A&E on previous occasions. The data highlights that present records do not provide a format that enables staff to carry out their work methodically. Thus, the possibilities of more time pressures are experienced. An indication is given here that they also felt distracted because of the limited amount of information available to read instantly. Therefore, this has influence on practice. Staff give an indication in statement 5 that issues of time pressures caused by working in such a challenging clinical area are real and

problematic. This type of reply infers that recognising risk factors were largely intuitive. Thus, staff were not comfortable in attempting to articulate their practice. This is because they may not have been following set procedures. They appear to be practising in a complex and uncertain environment, in which they are making decisions on a daily basis, relying on a mixture of professional judgement, intuition and common sense. Possibly, in some situations, they may feel constrained by what they can document and share lawfully. The ever present threat of accountability appears to have been allowed to push them into a defensive frame of mind which can lead to a feeling that they are in a situation where they cannot win. Their reply is also taken to mean that the experience, perception and understanding which are used derive from a social structure within the department. This could be because; the process of documentation is extricably intertwined with the social setting in which it is written.

When certain behaviours such as gestures from senior nurses were examined (Chapter 6), interactions and activities observed provided evidence that reveals that there are failures in considering the views of other colleagues. It is shown that there is an assumption that they and their subordinates hold the same views on documentation and information sharing. Given that this could significantly shape the views held by others, the behaviours communicated professional detachment and status, and an association with non–adoptive/adoptive approaches to hospital management. It also reveals that this interaction style affects the effectiveness of the way information is selected, recorded and conveyed within and between social environments. As a consequence the difference in views may well influence the extent to which a child's wellbeing is promoted.

7.2.5 *Theme 5- Imbalance in professional knowledge*

Following every serious case review, whilst the depth of inquiry and compassion is impressive, faults in record keeping continues to be highlighted as the effect and impact of serious recurring cases remain (Curtis, 1946; DHSS, 1974; Blom-Cooper, 1985; DH, 1988b; Kennedy, 2001; Laming, 2003; Bichard, 2004; LSCB, 2009). On a critical level, colleagues from a health and social environment need to communicate effectively in order to promote the wellbeing of children. For that reason, when our levels of knowledge are translated into reality, the result could be

conflict and/or frustration as it influences and shapes our responses to events and people, and the beliefs we hold ourselves in relation to our environment. In this group shown below there were four significant statements in one section:-

7.2.5.1 *Section 1- Significant statements - 1,2, 3 and 4*

1."*Without more training child focus will not occur. Dr T. identifying training in Junior Doctors"* (SD- LOCP focus group).

2."*Need some initiative and getting practitioners to think about risks/vulnerability"* (CSW – LOCP focus group).

3."*Training for Junior Doctors (change at 6 months) needs to be carried out each time"* (SN2- LOCP focus group).

4.*"A lot of needs for retraining. We need to check information each time they check in. Check the address, as who they are and not just go on the previous screen and just click yes*" (JN2- A&E focus group).

7.2.5.2 *Section 1- Formulated meanings - 1,2,3 and 4*

Perhaps the most fundamental reason why the staff may have considered identifying training as an issue is they may have felt that they do not have the appropriate knowledge required. A more basic reason seems to involve unease on the part of the staff about their competence and ability and may be they are just trying to be helpful. It appears that there is disappointment and unhappiness at the lack of opportunity for training in statements 2 and 3 which could contribute in enhancing the decision making process, particularly for junior practitioners. It is also demonstrating that without more training the roles of the staff with regards to child protection may be unnecessarily restricted.

The staff indicated in statement 4 that when one perceives professional responsibility for the wellbeing of a child the pressures for training is intensified. As a result anxiety may be provoked. They also gave the impression that despite their best efforts, they may be experiencing a sense of failure or even guilt. They identified the fact that they feel overstretched, undervalued and at times are

infuriated. Their view of the situation was interpreted to mean, that if they are busy and their minds are occupied, they are unlikely to pay attention to something that is of no interest to them (statement 2). If, however, within the wealth of information that is surrounding them, something which is relevant to current concern arises it is more likely to attract their attention. In turn, this heightens the chances of it being remembered. Moreover, they seem to be demonstrating feelings of dissatisfaction regarding the provision of the necessary resources needed for them to provide the appropriate levels of care.

These remarks in statements 1 and 2 were interpreted to mean that staff did not always feel that the need for training was supported by their managers. Therefore, it is intimated that perhaps the issue of training has been approached from their perspective; consequently, they relied on their knowledge of systems and practices to facilitate their training needs. Therefore, there was an imbalance in professional knowledge. As a result it is construed, that the situation had an element of apprehension, which included a frequent state of flight or fright. The point being demonstrated here is that individuals experiencing this dilemma regarding training, can be intimidated by it and are thus displaying their fear. For this reason, there appears to be a great deal concealed under the surface. For the norms to which they are accustomed, and much of what they are routinely aware, is guided by what they have come to expect. In addition, because the staff work directly with children, their deep understanding of safeguarding a child is essential if they are to promote their wellbeing. This response in statement 1 was also interpreted to mean that, although they were carrying out their professional tasks and responsibilities, they lacked a broad understanding of how their training needs should be addressed. The complete manner in which the issue of training was addressed, also led to the belief that training was needed.

There is a participant's belief in statement 3 that staff reaction to training is important and significant, and, because of the imbalance in professional knowledge, its importance could have implications on practice. Without more training, instead of feeling confident and competent, staff display a sense of insecurity, inadequacy and even unease which they attribute to the shortcomings of training. Lack of the appropriate knowledge may constrain their role unnecessarily,

since a deficiency in training opportunities may lead to despondency and discontentment. It may even contribute to and have pertinence in, decision making about their practice. It is also suggested that they are acknowledging their limitations. Perhaps, due to the reality of making mistakes or failing to achieve the desired objectives, combined with the awareness of the layers of complexities, a testing time is being created. This, in turn, is generating awareness that present issues regarding training are unsatisfactory, and that staff lack the skills needed to practice professionally. Moreover, it was interpreted that this type of reaction means that training was valued, not only for its contribution to documentation and the child's care, but also because it could be beneficial in enhancing the competence of the staff.

When one reflects on the issue of the deficiency of training, it is questionable as to whether this is the real issue here. In statement 1 it may be that the need for training is recognised, but instead of dealing directly with the issue, they are offering what can be generally called reassurance as this could be a strategy for avoidance. For example, redirection away from the topic may be seen as all that is necessary to satisfy professional requirements. If this is the method being used to avoid dealing with the subject, this response could close and/or discourage any further discussion. Therefore, it fails to be true reassurance that training is the solution. Hence, it appears that not much consideration could have been given to the issue of training, and as a result it looks as if short sighted policies are being offered. Consequently, lacking foresight in providing appropriate policies is likely to disregard the practices that would safeguard and promote the wellbeing of children.

In this context, the people responsible for the standards of record keeping may have been considered privileged since they managed the programmes for training. Therefore, knowledge appeared as a resource which was differentially distributed amongst the participants and it became apparent that it was closely linked with status and professional power, since some group members were given particular power to pass on knowledge through training, whilst others were excluded from having any influence or choice.

In order not to lose the richness contained in the data, at this point it was felt that no additional data could be generated from the protocols/transcripts. Through immersion and analysis, I have constantly returned to the problem at hand: the use of child records in A&E – the perspectives of staff. By so doing, I wanted to ensure that the account addressed the research question directly and did not wander off on interesting and important facts that were not quite relevant to the specific question. A total of 35 significant statements and formulated meanings, five themes and three theme clusters derived from the records, focus group discussions, and observational data (summary of data analysis is illustrated in **Figure 5.7** Chapter 5, and protocols are shown in **Appendices 11-13**).

7.3 Organising data into theme clusters

This stage of the data analysis was to combine the formulated meanings of the protocols/transcripts from all three stages of the study that represented specific themes, and also to organise similar coded themes into theme clusters (Colaizzi, 1978; Coffey and Atkinson, 1996; Kruger, 1997; Bloor et al. 2001). Following work on the printed versions of the transcripts, because there were relatively few codes, different colour highlights were used on the printed text, then a particular colour was used for multiple computer texts. Thus, for each transcript there were five files, each with only those segments pertaining to a particular code/colour. By using this process, the underlying concepts and cluster of concepts were identified (Colaizzi, 1978; Bryman and Burgess, 1994; Crabtree and Miller, 1999). For that reason, related concepts were grouped together to facilitate the coding process. Similar numbered themes were then assigned to clusters, and three theme clusters (demonstrated in **Figure 7.3**) that provided a rich picture of the phenomenon being analysed – the use of child records in A&E and the perspectives of staff - were extracted from the data.

7.3.1 *Theme cluster one communication and power*

The findings highlighted that existing child records have the potential to be a good tool for communication. However, they do not provide a format which enables staff to record information comprehensively. It is possible that this issue limits the ability of professionals to provide information to safeguard children. The structure should be an inherent part of a good record, thereby providing a prompt for the

required procedures. Possibly, by making adjustments to the model of child records, communication could be improved. The data also reveals that the social hierarchy in the interaction process, reflected power and higher status (discussed in Chapter 6), and indicates that this could cause differences in the staff's behaviour. As a result not only the communication and the record keeping process may be influenced, but also the practitioner child relationship may be impaired. The concept of the banality of evil (Arendt, 1994) offers some insight into the situation observed during this study, in view of the fact that it is intimated that, because staff's perceptions of the world are shaped by the cultural values in which they socialise, there could be a connection between the complicity with recording and the failure of thinking and judgement (Arendt, 1994).

7.3.2 *Theme cluster two - Assessment*

Theme 2 - Staff passivity - disengagement with the process of assessment.

Theme 3 - Recording – record production.

Theme 4 - Non- adoptive/adoptive approaches to hospital management.

Information from the data indicated issues that impede appropriate care for the child to be provided (cross reference to 5.20.3 and Figure 7.3). Various forms of passivity or disengagement with the process of assessment were identified and indicated that there may be a link to non-adoptive approaches of hospital management. The data showed that the awareness of layers of complexities associated with the work culture and processes are generating difficult conditions causing some of the issues relating to disengagement. The findings revealed that there are constraints encountered and highlights that present records do not provide a format that enables staff to carry out their work efficiently. It is demonstrated in the data that written documentation can be insufficiently focused on the child, illegible and incomplete and therefore can be imprecise. Thus there is the need to improve documentation, so that clinical information could be comprehensive and efficient. Record and record creation are important factors and have clinical significance, because they are essential for the provision of a child's care. One of the most important findings identified was the issue of omission of information from the records and the statements in 7.2.4 illustrates that staff have no way of addressing the problem. For, although problems are identified, there is a failure to address the situation.

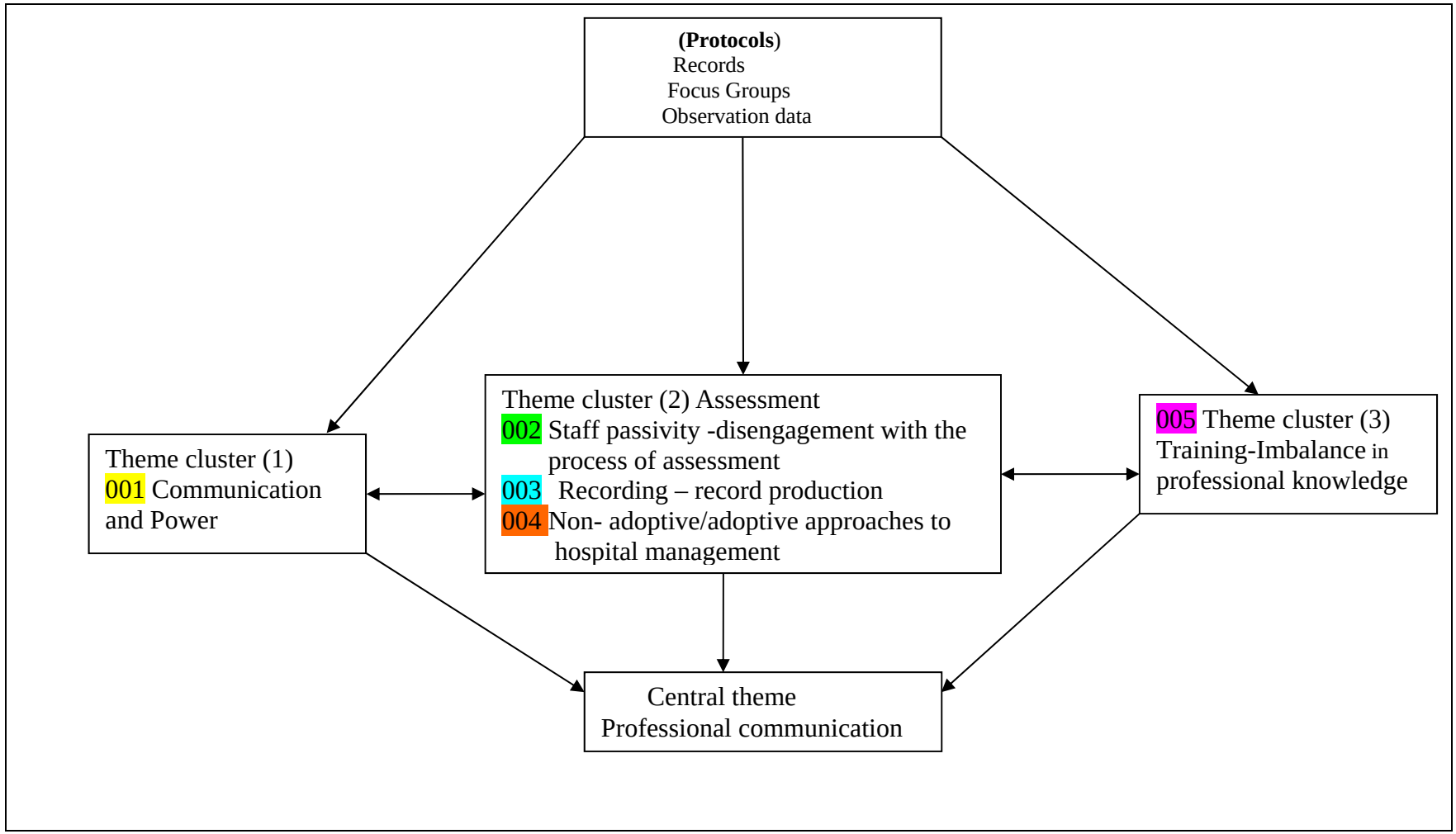


Figure 7.3 Theme clusters

7.3.3 *Theme cluster three - Imbalance in professional knowledge (training)*

Evidence from the study indicates that there is an imbalance in professional knowledge, which staff attribute to the shortcomings of training, and the need for training has been identified. Lack of the appropriate knowledge may contribute to, and have pertinence in, the decision making process. This includes the specific skills and knowledge required by every member of the A&E staff, together with ideas about how these might be acquired and developed.

7.3.4 *Linking theme clusters*

The meanings of the findings from the three theme clusters (demonstrated in **Figure 7.3**) were interrogated to determine if there was more than one central theme which expressed the essence of these theme clusters and ultimately that of the study. Although there is some overlap of the clusters, by their very nature, they are already an integral part of a whole and naturally co-penetrate each other. By going back and forth among the clusters, from the wealth of information gained during the analysis, it was decided that the pattern of elements of environment and language (discussed later) were so unified as a whole that its properties could not be derived from a simple summation of each theme cluster. The conclusion was that clarity could be drawn if a central theme was utilised, as this seems to both describe and combine the participants' practice in a way that makes sense. According to the work of Berger and Luckmann (1967) social interaction takes place in the environment in which interpersonal contacts occurs, therefore, language cannot exist without relationship to the environment. As a result, the encounters experienced by the staff in A&E were seen as taking place against a background of environment and language within the fabric of a social structure (discussed below, see also Chapters 8 and 9). Therefore it was determined that in this study the pattern of elements of environment and language were so unified as a whole that they revealed the central theme as being professional communication (illustrated in **Figure 7.3**), because it addresses the social construction placed on documentation and the cluster of meanings.

Higgs et al. (2005) suggest that communication between people is transmitted by language. Whereas Widdicombe (1995, p.107) draws attention to the use of

language and quotes “It is through discourse that material power is exercised and power relations are established and perpetuated”. The social construction of reality (Berger and Luckmann, 1967) theory argues that meaning is developed through interactions of people through concepts such as language and environment. It also recognises their importance to the way people make sense of their world, as social action is based on shared meanings and negotiations, enabling common definitions and meanings to be provided (Berger and Luckmann, 1967). With the intention of presenting an objective account of my study (Chapter 10), these two concepts were considered (1) being there-existing in relation to A&E (environment) and (2) models of systems (language). In addition, in order to provide a new framework (Chapter 8), McLeroy et al’s. (1988) paradigm of a social ecological system was utilised to draw up a structure allowing the characteristics of the A&E process to be located in the arenas of the two vital elements considered above. The precise process of classification and something of its complexity is presented in Chapter 8 and **Figure 8.1**.

7.4 Writing an exhaustive description of the phenomenon being studied

Colaizzi’s (1978) approach and the Hermeneutic Circle (Heidegger, 1962) was used in order to produce an exhaustive description of the phenomenon being studied (see Chapter 5). The existing research highlighted that although A&E child records are a good tool to convey information, these records are not sufficiently child focused. As a result, they do not provide a format which enables staff to completely record information, and is consequential on the attempts of staff to always recognise and identify risks factors. Findings from the study intimated that structure and process are crucial components required for effective documentation. Therefore, the effects of organisational structure and regulatory systems appear to trigger a lack of appropriate process which mitigates against generalised ideas, clarity of information and holistic documentation.

Based on patterns of association the data supports the notion that rules of the social group have become unclear to individuals, and do not provide a means of meeting their aspirations. Consequently there is staff passivity or disengagement with the process of assessment. It is also indicated that their behaviour could be linked to anomie. The work of sociologists such as Durkheim (1970) used the term anomie

to describe situations where people find that norms and values around which their lives have been structured are no longer applicable to their current situation. When a social system is in a state of anomie, common values and common meanings are no longer understood or accepted, and new values and meanings have not developed. The data showed that concerns or issues were not always recognised or identified by the A&E staff. In the light of the state of affairs currently within child protection, and serious cases of failure that have resulted in a series of Department of Health inquiries, elements of the discourse of this study show the hospital as a maladaptive process. So it is possible that the A&E staff may be struggling to maintain a sense of meaning in what they are doing, thus, feeling demoralised and stressed. Their comments implied that individuals experiencing dilemmas are intimidated by it and are thus displaying fear. This fear may possibly be linked to a sense of inadequacy, therefore they are concerned.

The ramifications of a failure to meet the needs of the child by means of effective documentation go much further than safeguarding and promoting their welfare. It is very much about communication within the organisation. Therefore the entire environment is affected. Evidence from the study shows that the situation has not been addressed; therefore a message is being sent to staff that ineffective documentation is not only acceptable, it is appropriate. That is why the hospital needs to be held accountable here. Not just for the protection of children, but for its simple refusal to acknowledge this fundamental truth - a maladaptive process is an expression of power, not democracy. Foucault (1977) refers to normalising judgment as the power inherent in all social expectations and explains that through interlocking disciplinary mechanisms power works on each of us to coerce compliance. Thus, findings from the observations of this study point to a society that has impelled its members to acquire effective documentation yet offered inadequate means for them to do so. The strain could cause many people to violate the norms. Social behaviour thus becomes unpredictable, since the only regulating agencies for staff would be the desire for personal advantage and the fear of punishment.

The work of Ashmos et al. (2002) describes how participation offers the organisation the opportunity to self-organise and evolve and adapt in more

effective ways, in so doing communication and the promotion of the wellbeing of children could be improved. Therefore, actions need to be taken in order to achieve the appropriate results. These include the evaluation of documentation, and an assessment of procedures. Thereby providing systematically developed statements that will assist the practitioner in making decisions about appropriate care of children within the child protection arena.

In this study, when current custom and practice were reviewed, certain tensions were identified. A state of tension exists between being the individual and being a member of a group. No doubt some of the tension encountered may derive from the way services to safeguard children are organised. For when a vulnerable child is encountered for the first time by a member of staff, each person's individuality is usually considered basic to good care of that child; however, this can be improved by good communication within a group. So it is possible that in some cases members of staff may feel that if they remain submissive within the group, the perils, which affect their existence, will be fewer. Whatever it may appear to be on the outside, the situation is charged with emotions which exert a powerful and frequently unobserved influence on some members of staff. Since there are hidden implications, evidence may not always be scrutinised in relation to the truth.

The safeguard and support of children appear to be glossed over and some staff appears detached. Issues concerning the child's welfare appeared to be simplified and accounts of realities sanitised. Much of the complexities of interwoven relationships are reduced. Thus, the inadequacies and implications of incomplete documentation are not reflected. Therefore, these issues appear to influence and delay the development of the staff's ability in fulfilling their safeguarding roles. Hence, they fail to ensure measures are in place to best protect the interests of children. As a result inadequacies cannot be remedied by improvement in procedures alone; therefore, there is a need for training.

In the findings, the lack of training has been identified as being significant, nevertheless, although training is important and may be considered a problem; it is not a solution since it is only one element required for the improvement of documentation. For training is not just about improving education of practitioners,

but also about offering a better service to children. If done correctly, with other colleagues having the right attitude, it could be very effective, because the complexities and ambivalences in human relationships, such as the routines that clinical workers thrive upon, can be updated and simplified.

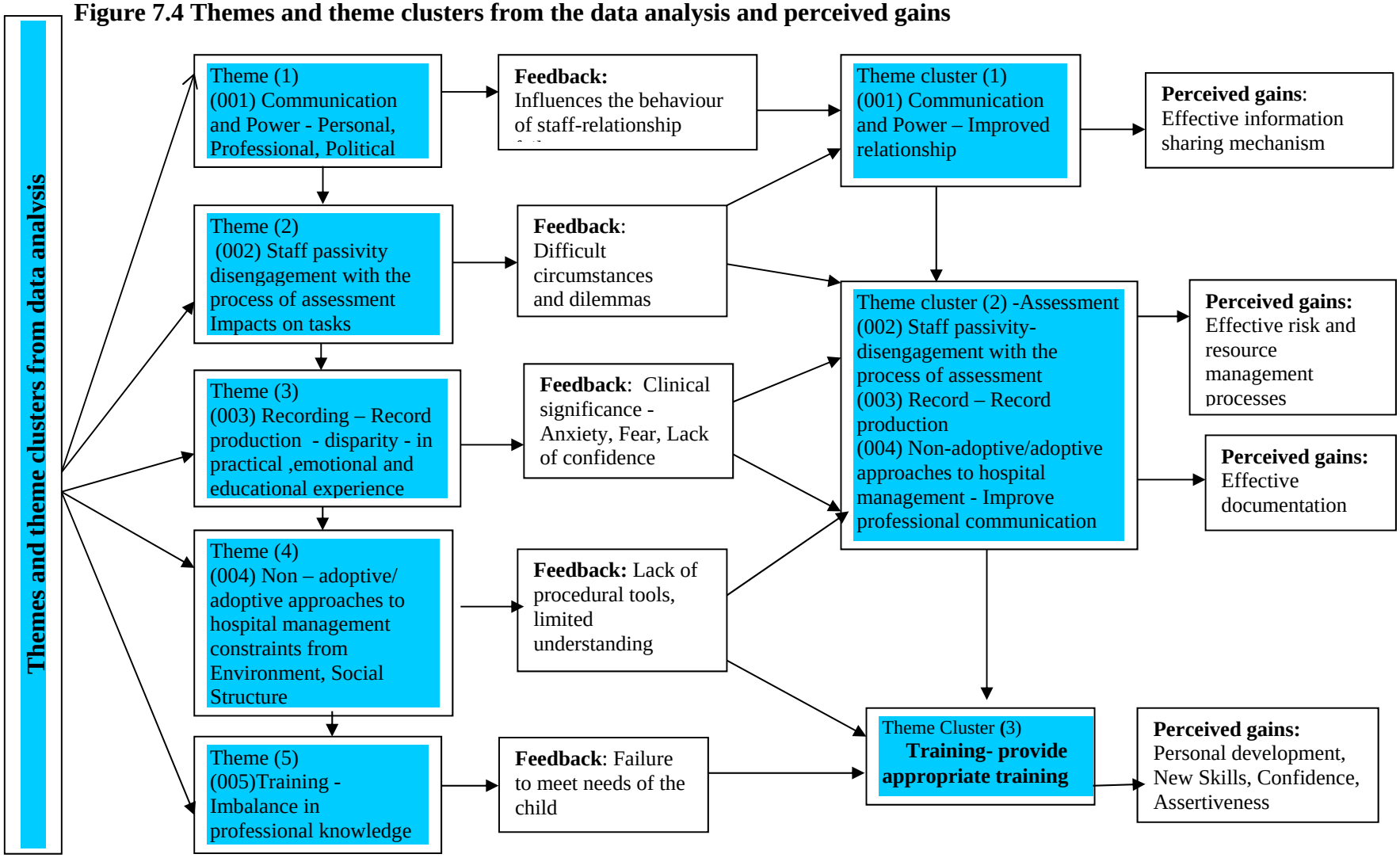
7.5 Validation

The final step in the data analysis is validation (see Chapter 5). This is when the researcher returns to the participants and asks them to review the results. Feedback regarding the data together with the emerging findings and interpretations were given to the study participants (Guba and Lincoln, 1985). Firstly, this was achieved by making both formal and informal presentations at A&E and LOCP meetings, as an on-going process, during and after data collection. Secondly, validation was also undertaken by returning to the participants and asking them if the description validated their experiences (Guba and Lincoln, 1985). All participants expressed the view that the description of the use of A&E records had congruence with their experiences and was an accurate description of the essential structure. The research participants and the immediate stakeholders also felt that the results were useful; therefore, they offered positive comments and support for the study [41]and this in turn generated warrant for action, therefore, the records have now been redesigned (see Significance of the study Chapter 9 and Appendix 36).

As I worked alone, the steps of extracting significant statements and creating formulated meanings from the transcripts/protocols were done independently by me, the researcher. Hence peer debriefing took place during my PhD tutorials with two academic supervisors, who approved the hermeneutic phenomenological analysis as being suitable for the task. The analyses were compared and found to be similar to the participants' opinions, except for my inclination to use nondescript language when formulating meanings that did not reflect the depth of feelings of some significant statements. The formulated meanings were subsequently modified to accurately reflect the participants' lived experience. Presentations of the findings have been made to two research groups for questions and criticisms, peer support and constructive criticality has been particularly useful.

[41] See e-mails **Appendix 19**

Figure 7.4 Themes and theme clusters from the data analysis and perceived gains



The final process of validation was completed by referring back to the original transcripts, during and following data analysis, to ensure that the issues, concepts and contextual realities had been suitably explored, and that it accurately represented the phenomena: the use of A&E child records from the perspective of the staff who use these records. Additionally, a short article of the current research project was published in a professional journal[42] and in May 2010 a collaborative audit was conducted by the Acute Hospital Trust (Chapter 6). As a result of the audit, a clear need for improved communication and training was identified. Themes and theme clusters from the data analysis and the perceived gains of effective documentation are illustrated above in **Figure 7.4** and are linked to computerisation of records Chapter 2 and potential benefits for improved A&E child records in **Figure 2.6**.

7.6 Conclusion

From the wealth of information gained during the analysis of this study, significant issues regarding communication and power, staff passivity-disengagement with the process of assessment, recording, which includes record production, non-adoptive/adoptive approaches to hospital management, and imbalance in professional knowledge (training) were highlighted. Individuals providing information may well understand all of its implications, yet fail to realise that the person(s) receiving the information may not. Additionally, the person(s) receiving the information may not recognise that there are implications, but if they are unsure, they should make enquiries. The information considered being basic in one discipline may not be so in another. For example, an expert in one discipline may not be aware that an expert in another discipline does not understand the implications of the information shared. The findings of Laming's (2003; 2009) enquiries show, that in order to safeguard children's health and wellbeing, it is crucial for accurate timely information to be shared. The evidence presented here portrays that those individual incidences, which first appear to be inconsequential, may well be viewed differently when the full picture is presented. Evidence from stage one confirms the findings from both stages two and three of the study. The following chapter relates to the analysis - presents a proposal for a new framework.

[42] Forge, 2010, **Appendix 35**

Chapter 8 Framework for effective documentation

Introduction

This chapter discusses a new framework in relation to the importance of the human element placed on documentation. Several theoretical approaches (Chapter 4) and the analysis of the findings were explored in order to obtain knowledge relevant to this study. They have contributed to the development of a new framework for A&E documentation, by identifying key issues which are currently affecting communication. They have also enhanced my understanding of the relationship between effective documentation, and the desired outcome of promoting the welfare of all children. Documentation and information sharing are not just natural objective phenomena; they are constructed by a whole range of different social arrangements and practices referred to by Berger and Luckmann (1967) as multiple realities existing. On one hand, underlying the issue of documentation in healthcare is a fundamental philosophy of practice. On the other hand, within professions, there are attitudes about relationships with other professionals, and different qualified specialities which can lead to similar perceived differences in status.

8.1 Local process

The communication process for sharing information locally follows both an internal vertical (up and down the organisation's chain of command) and an external horizontal process (information exchange between departments as a means of coordinating activities). This process of communication moves vertically throughout the hierarchy structure, and horizontally as required by partnership working (HM Government, 2010), for example communicating with social care. According to the work of both Handy (1993) and Mullins (2010), vertical communication is initiated at higher levels and flows down to lower levels, whereas horizontal communication refers to communication among people who have no hierarchical relationship. Since the vertical channels follow the lines of authority in the local A&E department, McLeroy et al's. (1988) model, (Chapter 7) was utilised to draw up a framework to represent the lines of communication (presented below in **Figure 8.1.**) It should be remembered, however; that the practical network is very much more complicated than it appears in this simplified diagram, for departments such as this A&E have a

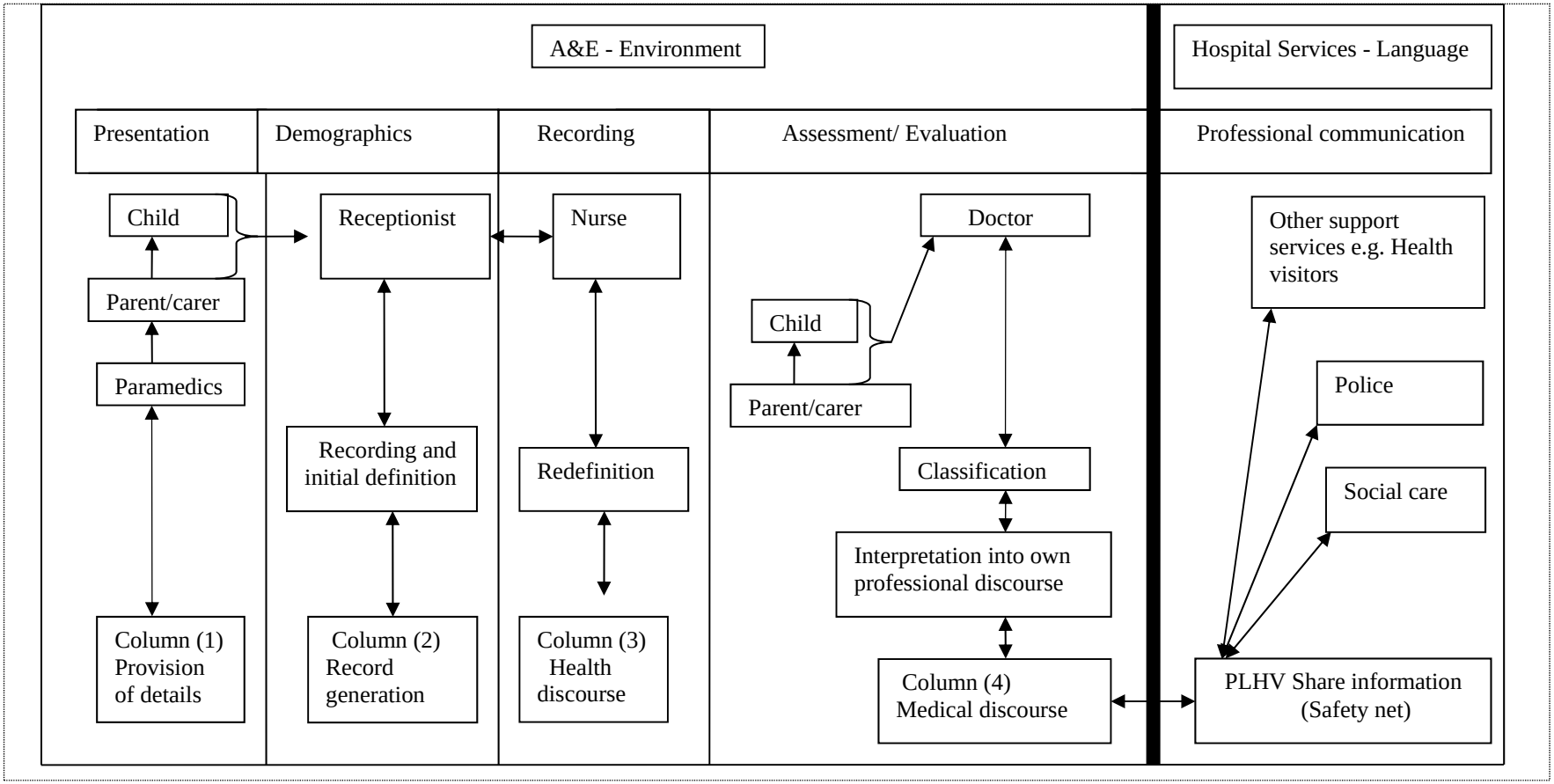


Figure 8.1 A&E process of classification: Definition – Shaping of a social issue into a medico-welfare problem

communication chain of their own. Therefore, they depend on its daily function and process of categorisation to shape a social issue into a medico-welfare problem. As a result, the instructions of management moving downwards through the department and information passing upwards to management will follow the authority line of the organisation. This process has developed over many years. Hence, it is important to realise that the titles given to A&E employees do not necessarily reveal their level of knowledge. As a result, in some situations, record generation may be impeded by, for example, different levels of knowledge, perceived differences in relationship, power and status, so potentially important information may be overlooked.

Locally, the procedure for a child attending A&E (see Chapter 5) is that they go first to the reception desk where the receptionist takes details and generates notes. These are passed on to the nurse who then sees the child and parent/carer and makes an assessment; the child and parent/carer are then seen by a doctor who examines the child (demonstrated above in **Figure 8.1.**) and he or she then receives the necessary treatment, is either admitted to hospital or discharged. The research has shown that in the majority of cases, during the history taking process, the parents speaks on the child's behalf even when the child is able to speak for themselves (Chapters 6 and 7). This could mean that the child's view is not always considered.

The research has also highlighted the fact that the cause for concern for the child's welfare is not always identified or recognised by those persons caring for the child. This is contrary to safe and effective practice (GMC; 2006; NMC, 2008; HM Government, 2010). Shortcomings in the service have also been identified, as there is a substantial amount of reliance on the role of the PLHV which is meant to be that of a safety net. Thus it may not always be possible for the service to be effective and efficient. From my observations and experience the process being followed lacks the necessary knowledge and skills required for integrated working.

In A&E, even when the medical encounter seems to be an interaction between mutually understanding individuals such as the doctor and nurse, in some regards they belong to different worlds (Strong and Robinson, 1990). As a result, power

issues have a strong impact on their relationship, assigning power to the doctor to decide what information is valid. The notion that a process of social influence is taking place in documentation, suggest that it is characterised by both latent and formal explicit methods that are likely to affect the decision making process.

Evidence in the findings (see Chapter 6) suggested that both informal and formal influences are associated with A&E documentation. With informal practices individual's judgements are based on information obtained, not only directly from their own experience, but also through the opinions of other group members (O'Reilly and Caldwell, 1979; Kaplan and Miller, 1987; Turner, Wetherell and Hogg, 1989). The formal process is consistent with the active use of power derived from seniority within the department. Therefore, differences in experience and/or status intensify conformity effects, as the people with the power are likely to influence others (French and Raven, 1959; Raven, 1965; 1993). As well as the issues of power when children are assessed, some members of staff may view the experience of seniors (for example nurse manager, lead nurse for paediatrics) as meaning that the senior's judgements should be the most important. As a consequence there could be a combined effect of informal and formal influence.

This may be consequential to the consistent poor quality in the recording and sharing of pertinent information across agencies which indicates that patterns of neglect and maltreatment of children remain (Laming, 2003; 2009; Munro, 2011). As a result the government has demonstrated a commitment to safeguarding children by commissioning reviews of the child protection system (Laming, 2003; 2009; DfES, 2004a; HM Government, 2010; Munro, 2011). Consequently, within the child protection process, there are changes in children's legislation to promote their welfare (Chapter 3). Each government report identifies that this course of action depends on effective partnership between agencies and professionals and makes the association with documentation.

Some authors indicate (Payne, 2005; Compton and Galaway, 2005; Coulshed, 2006; Howe, 2009) that, in situations where issues relating to effective documentation and information sharing are sought, it would be possible to assign the degree of effectiveness achieved to one of the approaches influencing social

systems, for example, models such as the HBM commonly used in practice. However, these models (Chapter 4) do not allow for the complex inter-relationships that I have observed and experienced in this project, such as the informal/latent and formal process of documentation. Therefore, these models could not accentuate the many critical issues of documentation that lay in the social construct. For that reason, using one of the models that influence social systems is inappropriate, as the encounters experienced by the staff take place against a background of environment and language (Chapters 7 and 9) within the fabric of a social structure. The significant points (Chapters 2, 4 and 7) also indicated that they are a feature of complex interaction and negotiation between an individual or group and meaningful context of experience. This includes what is relevant to the task in hand (purpose), background information, expectations and what is taken for granted (Crabtree and Miller, 1999; Porter, 2002; Polit and Beck, 2008). Hence it is important to aim for a framework that is relevant for this study. As a result a new conceptual framework emerged[43] which attempts to show the complex and multi-faceted nature of documentation and information sharing. It also offered equal emphasis to the participants, their environment and interaction, providing an understanding of how the natural and human created environments affect our behaviour.

According to Berger and Luckmann (1967), we exist in an environment shared by other human beings, but we can create and re-enforce reality, both subjective and objective. In view of the fact that our environment determines the nature of our language and action (Berger and Luckmann 1967), it contributes to the structure of the connections of people to one another and to the activity of record keeping (see Chapter 9). Since the use of A&E records here occurs within an organisational context, it is considered appropriate to specifically address how they are contextualised by the communicative situation in which they are used. The issue then is one of locus of control and influence. This is grounded in the expectancy-value theory, which describes human behavior as determined by the perceived likelihood of an event or outcome occurring contingent upon the behaviour in question, and the value placed on that event or outcome (Rotter, 1966). Whereas Rotter's (1966) conceptualisation views locus of control as one-dimensional,

[43] Figure 4.3, Chapter 4

Levenson's (1973) multidimensional model measures beliefs and asserts that there are three independent dimensions, Internal Control, Control by Powerful others and Chance. Internal (meaning the person believes that they control their life) or external (meaning they believe that their environment, some higher power, or other people control their decisions and their life). According to Levenson's (1973) model, one can endorse each of these dimensions of locus of control independently and at the same time. For example, a person might simultaneously believe that both oneself and powerful others influence outcomes, but that chance does not. Applying Levenson's model (1973) to A&E generated a pattern of relationships similar to the pattern found in the outcomes of this research demonstrating that (Internal) there is the belief by members of A&E staff that taking a particular action will produce suitable outcome for a child, (Powerful others) A&E staff are directed and evaluated by those in authority and (Chance) providing suitable documentation viewed as contingent on luck. Utilising Levenson's (1973) model a format of environment and language impacts on documentation, which, in turn informs, the focus and configuration of the resulting action.

8.2. A new model

8.2.1 *A&E perspective*

Evidence (see Chapter 6) my experience and the model in **Figure 8.1** support the notion that there is a need for the model in **Figure 8.2 below**, as there are no readily available practical models in the department. However, some government documents such as the Information sharing: Guidance for practitioners and managers (DCSF, 2008) do provide details for service delivery pathways. Participants in this study also agreed with the redesign of the records[44] and all thought it was valuable.[45] They also believed that in order to provide effective documentation that are equipped to safeguarding children, the model in **Figure 8.1** that demonstrates how the local procedure in A&E currently works should be upgraded to the model in **Figure 8.2** (see also Chapter 10). The participants acknowledged that they should be the ones to improve documentation, as they are responsible for the quality of care and records they provide. This framework in **Figure 8.2** sets out to give structure to a

[44] **Appendix 36**
[45] See e-mails in **Appendix 19**

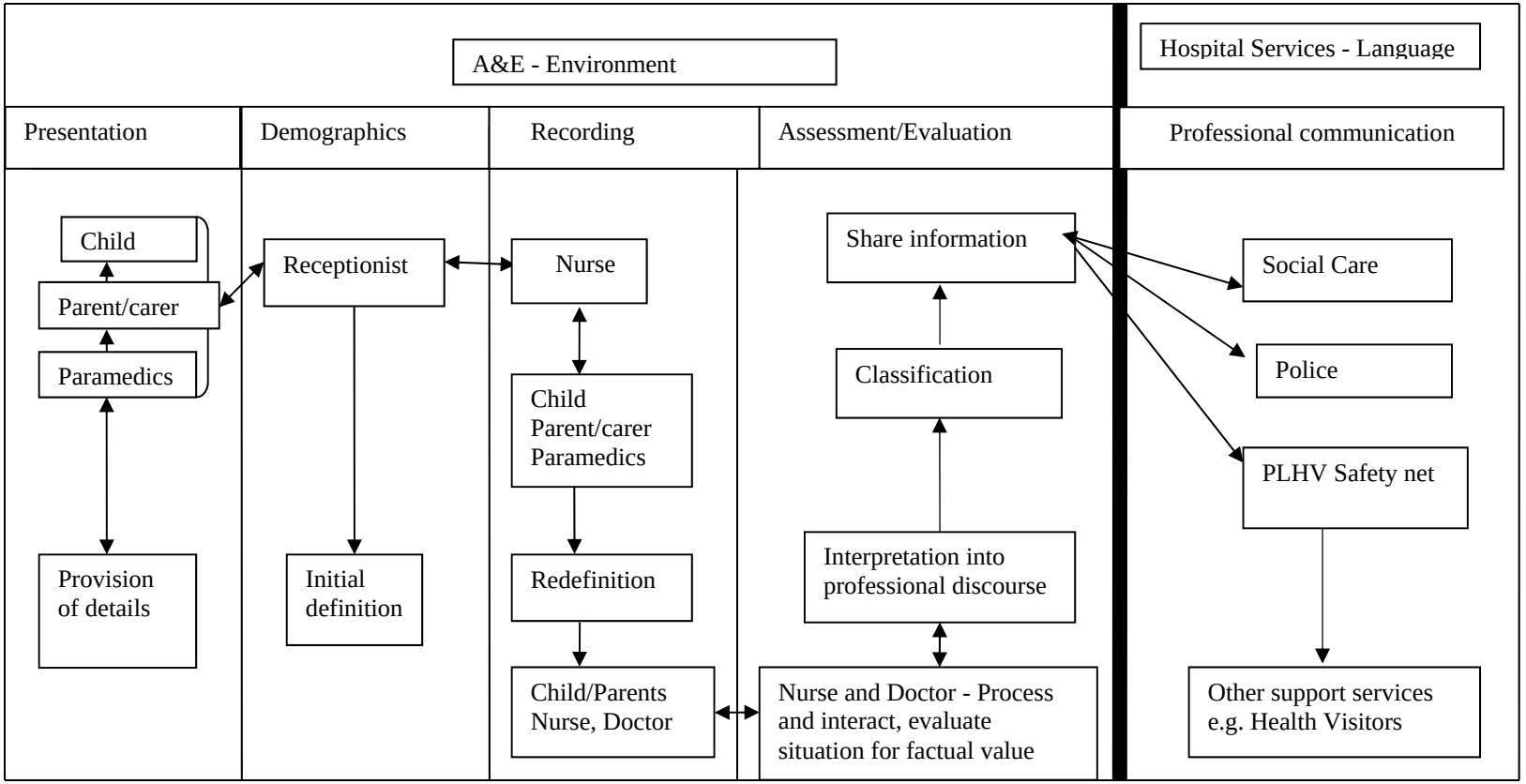


Figure 8.2 Social Constructivist- proposed new model A&E: Activity-records/documentation

process by which colleagues in a health and social environment can work to achieve the required documentation to safeguard a child. If this model is to work, the procedure for a child attending A&E, should be that the child, parents, and paramedic first go to the reception desk where the receptionist takes details and generates notes. The nurse should then communicate with all those previously mentioned before an assessment is made so that the nurse is familiar with the case. Subsequent to this the nurse should be present when the child and parents are seen by the doctor, and after the examination both the nurse and doctor should evaluate the situation for factual value and make the required decision. Following this process the professionals treating the child would have a complete vision regarding behaviour, concern or any other non- medical indicators of the child and family.

By using this approach, the people tending the child would be able to identify any cause for concern, as a result accurate and effective documentation should be ensured, thus avoiding discrepancies and misunderstanding. This method should not only promote and provide an effective and efficient service, it should also enable the PLHV to fulfil the role of being a safety net. This model differs from others in that it offers a unified view of the whole; therefore, it focuses on the inter-relationships which influence documentation (Siporin, 1975; Maluccio, 1981; Garbarino, 1982; Gilbert and Epel, 2009; Jorgensen, 2010; Brown, 2010).

The framework proposes that documentation in a social constructivist research can be usefully conceptualised in terms of the degree staff (both as individuals and members of a group) value and perceive the use of records. In addition, the framework acknowledges that within a social constructivist research project, the balance of assessing each situation can shift between different practitioners, since it has the flexibility to work with a variety of practitioners from overlapping theoretical bases, whilst still maintaining collaborative practice. Thus the model in **Figure 8.2** can be converted to the model in **Figure 8.3** to augment organisational information process (see Chapter 10)

The framework also acknowledges that people and the environment are interconnected in an active process of mutual influence and change, and conveys that record keeping should be considered within the context of the everyday world

of A&E (Siporin, 1975; Maluccio, 1981; Garbarino, 1982; Gilbert and Epel, 2009; Jorgensen, 2010; Brown, 2010).

8.2.2 *Organisational perspective*

In the past, models of communication have been over simplified (see Chapter 10) as they were taken from the scientific principles of communication; therefore the social constructive perspective has been omitted. For that reason, a more realistic model is proposed in **Figure 8.3** below that can enhance organisational function in the process of change through mutual understanding (see Chapter 10).

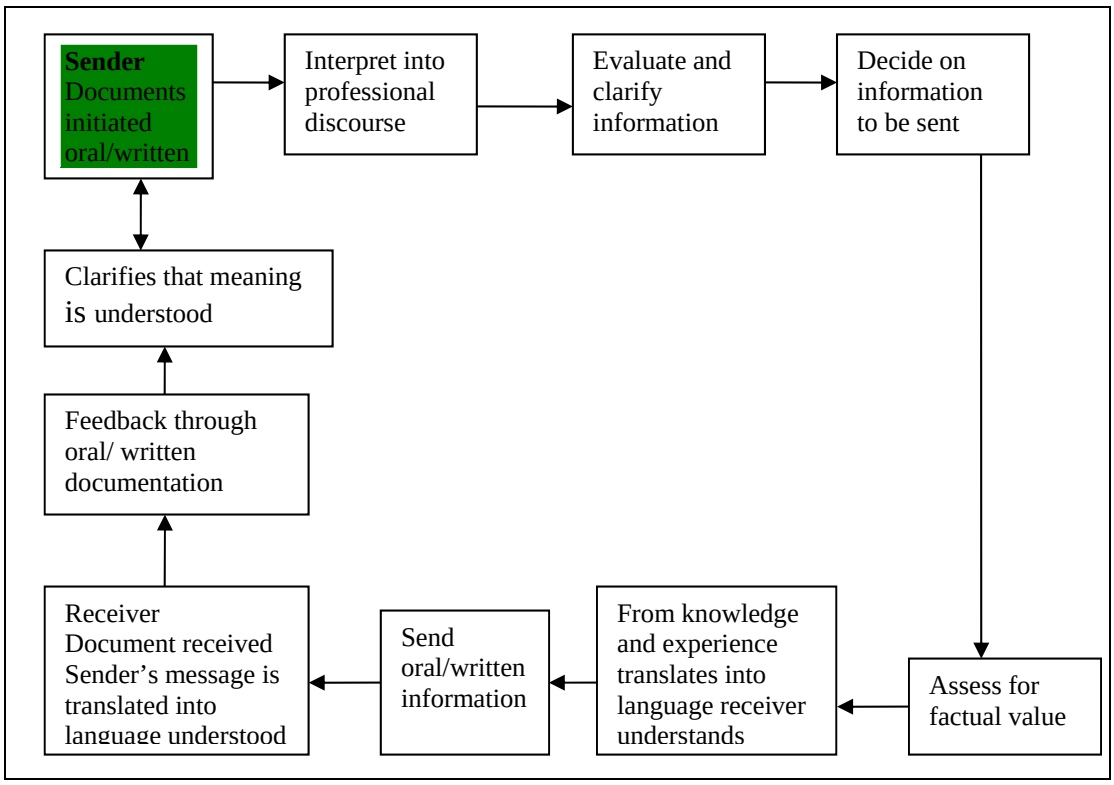


Figure 8.3 Organisations- proposed new model for information exchange

8.3 In conclusion

In this study, social construction has undoubtedly played a crucial role in documentation. According to the work of Berger and Luckmann (1967), an individual is born into an objective social structure in which they encounter the significant others who are in charge of their socialisation. Whilst the individual is real to him or herself in a certain way, socialisation guarantees that they continuously respond to their experience of the world with help of their perceptive and emotive patterns appropriate to this reality. Using this framework to look at

documentation we do not have to fall victim to the situation, because we can try to alter it, since we create and re-enforce our own reality and become masters of our own destiny. Thus in an A&E environment, if making decisions is conceptualised in terms of understanding the purpose and mode of documentation, authentic decisions could be made from the assessment of each situation. Therefore, practitioners will no longer be forced to justify why practice cannot be changed, because they will be able to take responsibility for their documentation.

Chapter 9 Discussion

Introduction

It is evident that there is a very limited body of work which focuses on documentation and information sharing within the arena of safeguarding children/child protection. Studies have identified documentation of childhood injuries in A&E as being inadequate. Research conducted in the United Kingdom and elsewhere tends to focus on process issues, standardisation, protocols and procedures. Some other studies, such as nursing documentation in A&E, the flow of information between doctors and nurses, recognition and reporting of child maltreatment, and information relating to the possibility of non-accidental injuries were also examined. These were not in-depth studies and gave no indication of how their ideas could influence staff's values and perceptions of documentation. In the United Kingdom, involving staff has tended to be based on serious cases of failure which has resulted in a series of Department of Health inquiries and reports (Laming, 2003; 2009; DH, 2004a; LSCB, 2009; HM Government, 2010). Whilst the importance of such work developing in the area of safeguarding children is acknowledged, the importance of the human element on documenting and the conveying of information have not been addressed.

9.1. Significance of the study

This study is significant because it focuses on the neglected area of documentation. In this investigation the A&E staff and the LOCP group were specifically consulted to elicit their values, views, and perceptions of the use of child records. The notion that this study involves the meanings of what people record and communicate indicated that it was their perspectives and experiences that needed to be explored. This conceptualisation is evidence that where difficulties exist, it should be the collective views and perceptions of the participants that would give a realistic explanation of their experiences.

It is also evident from other literature that the approaches used for documentation and information sharing derive from a knowledge base which is multi-faceted. Therefore, the practice of information sharing is broad and includes children, communities, social, cultural, political, economical and other factors. As a result

both natural and human elements influence people's behaviour (Burnard, 1997; Baker et al. 2002; Alder and Rodman, 2003; Higgs et al. 2005). The use of child records is also multi-situational, because their contents are shared with other colleagues within in a health and social environment in particular situations such as child abuse (NPS, 2003; DH, 2004; DH, 2004a; DfES, 2005; DfES, 2006; HM Government, 2006; DCSF, 2007; HM Government, 2010).

In such cases the situation can occur as a result of multiple factors involving the child, the parents, their life situation, and a series of events. As a result, there is a range of intervening variables that are due to the complex aggregating range of factors associated with the child's assessment and care (Hagell, 1998; Bell, 1999). Evidence shows that there are no unifying processes for clarifying that the required information is communicated appropriately (Laming, 2003, 2009; Munro, 2011). So there is a spectrum of models for the safeguarding of children which covers a wide range of activities from prevention and awareness, examination and treatment of abused children, through to the protection of children and young people from suffering harm from abuse and neglect, and to prevent them from offending (DH, 2004; DH, 2004a; DfES, 2005; DfES, 2006; DCSF, 2007; HM Government, 2010).

There is, therefore, a wide variety of variables relating to the use of A&E records, but we have comparatively little basis for judging the relative importance of them (Parton, 1998; Hagell, 1998; Kemshall, 2002). Hence, the existence of the use of different approaches, each with their own advocates, sets up a tension between approaches to information sharing, which may be spurious between (a) communication for early intervention, which ensures that children and young people with additional needs receive the services they require, and (b) the on-going care within the child protection arena, of the child and their family. Therefore I concur with the view (Parton, 1998; Hagell, 1998; Kemshall, 2002), that in practice the use of different approaches may relate more to the context of the sharing of information and its purpose rather than the framework per se.

For when a child presents to A&E, a range of professional involvement is necessary for the completion of a child's assessment (illustrated in **Figure 8.2)**. For that reason, there should be careful, clear and accurate recording and

integration of documentation to facilitate the essential planning and decision making process (DfES, 2004a; HM Government, 2010). As a result, the tension has manifested itself into two predominant approaches, communication and the sharing of information effectively both vertically and horizontally. In view of the fact that the A&E structure has an authority and communication chain of its own, information is communicated vertically. Subsequently, given that information is shared with others there are horizontal links as communication takes place between professional agencies such as social care, who may be involved with the child and family (see Chapter 8).

For that reason, if the documentation is either damaged or incomplete the mechanisms by which records are used affect the ability of other professionals to safeguard the child. Thus, because of the lack of standardisation and consistency between a health and social environment, insufficient information may be taken at the initial point of assessment. As a consequence the decision making process may not be effective and may result in some children receiving minimum support for their needs (Laming, 2003; 2009). Evidence from this research and others (Laming, 2003; 2009; Munro, 2011) has shown that although ineffective documentation contributes to the early demise of some children, issues relating to this subject are still not being addressed. So it is important to understand the significance of documentation when child records are used as a means of communicating. It is clear from the response of the participants in the study that they recognise the importance of effective documentation and its association with professional communication.

As a consequence of this research, documentation has been improved within the A&E department on the research site and has been implemented. Records have since been redesigned (shown in **Appendix 36**). The new documentation in the department is now in an A4 format. They are generated by the receptionists when demographic details are taken on the child's arrival in A&E, a copy is printed so that members of the multi-professional team for example nurses, doctors, can enter clinical details manually. Once the child is treated and is either admitted to hospital or discharged the details from the records are then scanned on to a computer system and the documents are shredded. There is a single page of the clinical notes

that clearly identifies and is dedicated to addressing safeguarding issues and there is a section for any necessary action taken. The new records cover both adult and paediatric safeguarding concerns and include questions such as: frequency and delay in attendance. Capital P and A on the top left side of the first page indicates that the records belong to a child P (Paediatrics) or A (Adult). Practitioners find that the new design is far more effective.

9.2 Understanding and interpretations

Documentation is promoted as an essential tool for underpinning good child protection practice, because it is considered a fundamental part of a child's assessment (Laming, 2003; 2009 DH and DfES, 2004b; HM Government, 2010). In keeping with the findings of existing research (Christopher et al. 1995; Green et al. 1998; Benger and McCabe, 2001; Taitz et al. 2004; Laming, 2009; Gilbert et al. 2009), the evidence from my study recognises the fact that effective documentation is important, and that written records are essential instruments for communication.

In general the practice of using records for the purpose of safeguarding children has been and, in many cases still is, impaired by poor record keeping (Laming, 2003; 2009). The safeguarding of children may at times be severely restricted by the nature of documentation (Laming, 2003; 2009; HM Government, 2010). The issues of documentation and information sharing are also long standing problems (Curtis, 1946; DHSS, 1974; Blom-Cooper, 1985; DH, 1988b; Kennedy, 2001; Laming, 2003; 2009; Bichard, 2004; LSCB, 2009). This has been very evident in my research. Carter et al. (2007) who have audited nursing documentation in an A&E department in South Africa, gave similar findings and concluded that record keeping was inadequate. Others who have made observations about documentation and information sharing have also uncovered comparable results to this research study (Benger and McCabe, 2001; Taitz et al. 2004; Sanders and Colbey, 2005; Law et al., 2006; Gilbert et al. 2009).

This study's framework identify that there are shortcomings in the current documentation. For example, failure to recognise or highlight causes for concern, records are illegible, inaccurate and incomplete. The findings also reveal that a

major difficulty concerning the safeguarding of children is the insufficiency of information from written documentation, upon which to make informed decisions.

According to Armstrong (1996), the history of protecting children from abuse has illustrated on many occasions the importance of good record keeping. She introduces poor record keeping by illustrating that the picture one may have of the issues surrounding the safeguarding of children may at times be severely restricted by the nature of the record keeping. Significant issues regarding content and accuracy of records are highlighted in my study and the importance of this evidence is supported by Armstrong (1996). Therefore I concur with her work, for where children are concerned, it may be vital that a fuller picture is necessary in order to ask the right questions and make the right decisions. Participants in my study agreed and emphasised that any shortcomings in documentation may create multiple difficulties for another agency/professional to which the child is referred. This is important, because in reality the situation is made more difficult for professionals to make a correct assessment at a later stage, if the appropriate information has not been initially obtained.

It is significant that although a cause for concern was picked up by the PLHV in 73 records out of the 378 that were audited; the A&E staff had failed to highlight this cause for concern in 49 (Chapter 6). The role of the PLHV, as intended by the Primary Care Trust (PCT) and in line with the recommendations of both the Laming reports (2003; 2009) and the RCPH (1999, 2007), is to be a safety net only. Therefore, it is contrary to safe and effective practice for the PLHV to be the main/primary source of highlighting a case to be one of concern, and then forwarding the referral to the necessary agencies. Good, safe professional practice, in line with the Laming (2003; 2009) recommendations are that the referrals should be made by the healthcare professional who has examined the child and can make an appropriate referral based on medical and non-medical indications, such as distress, demeanour, which usually cannot be made after the event.

Evidence from the study shows that there were 67 children who had follow up appointments or referrals to specialist practitioners or other agencies recorded and, and six did not. It is also relevant to note that there was insufficient documentation

for six children. This is significant, since it is being indicated that they may not have been treated appropriately. As a result their welfare may have been compromised; this may have meant that they have not been safeguarded.

It is significant that this study has found that that there is a mismatch between examination, observation and what is documented in each of the A&E records. What is said to be a problem on admission is different in the final documentation. As I have stated elsewhere (Forge, 2006; 2010) doctors in A&E miss clues of abuse, because they do not look for them in the history and examination, and that they also document their findings poorly. This indicates that perhaps the story is not separated from the actual assessment of the child, which suggests that staff may not be doing any more than is required by policies and procedures.

In the findings from other studies (Benger and McCabe, 2001; Taitz et al. 2004; Sanders and Colbey, 2005; Law et al. 2006; Gilbert et al. 2009) there was the tendency to investigate data that relates to injuries, standards, and procedures. Attention within policy literature has largely focused on difficulties in practice and the work of Christopher et al (1995) demonstrates some of the discrepancies found in documentation. Whilst there are common threads in the work of Sanders and Colbey (2005) that support my work, they focus on non-accidental injuries, which detract away from the importance of appropriate documentation. Other studies (Benger and McCabe, 2001; Taitz et al. 2004; Law et al. 2006) Gilbert et al. 2009) demonstrate a degree of congruence with my study, nevertheless the importance of appropriate documentation is not identified or discussed. Therefore, narrow conclusions may have been drawn in relation to this topic. What stands out overall is that there is little focus on effective documentation even though this issue continues to be unresolved. It is also important to note that other studies (Benger and McCabe, 2001; Taitz et al. 2004; Sanders and Colbey, 2005; Law et al. 2006; Gilbert et al. 2009) analysed in the review of pertinent literature, have not considered the role of the PLHV during their investigations.

The findings of this research also indicate that parents provided the history for most children. It is possible that when history from the child is taken, staff may be influenced by variables associated with socially constructed processes. As a result

in an A&E environment their thinking may be inhibited. For example, failure to consider the child's level of intellectual development (DH, 1989; DH, 2004). Crucially by acknowledging and responding to the child, the A&E staff are responding to them as a person (DfES, 2004a; DH, 2006). For that reason, concern for their feelings, communicates concern for their welfare. For when the A&E staff perceive themselves contributing to the wellbeing of the child, protectiveness may be increased. Perception therefore plays an active role in documentation and information sharing.

9.2.1 *Perception*

Because people's perception is especially important in healthcare, it influences how we behave towards each other; this is turn influences what we communicate (Fielding, 1995). Evidence from the findings indicated that members of A&E staff do not always interact with the child. It is possible that the A&E staff's perception is that by interacting with the child directly, their vulnerability will be increased. A more basic reason, involves anxiety on the part of the A&E staff about causing upset. In which case, they may feel intimidated by parents if they do not possess the degree of openness and self-confidence to enable them to deal with different situations. Others, perhaps, may not like to say that they fear abuse from parents, and may be left feeling that they have somehow failed the child. So rather than admitting that they are fearful, it is possible that they continue to maintain the illusion of professional omnipotence of focusing on the child, when in fact they are not.

My point regarding staff's perception, is not shown in other studies, but it is supported by Fielding (1995, p.20) who refer to perception in the context of behaviour as being an active process, relying for a large part on habits and possibilities to filter and simplify information load. He wrote "these habits lead us sometimes to see things that are not there at other times miss those that are there". In Bandura's (1997) social cognitive view of human activity, self-efficacy cognitions are the attitudes, beliefs and perceptions we have of our abilities in relation to interactions with the rest of the world. He argues that although the environment does influence behaviour, people choose, through cognition, what they want to see and how they perceive their environment.

It is evident in the findings that documentation can be incomplete and inaccurate. Safeguarding children depends on partnership working (DfES, 2004a; HM Government, 2010); therefore for children presenting to A&E their care may sometimes be provided by multi-disciplinary teams. Such teamwork can bring benefits to a child's care, but problems can arise when communication is poor or responsibilities are unclear (Hornsby, 1993; Lethard, 1994; Loxley, 1997; Freeman et al. 2000). Therefore, it is possible that changes in shift or responsibility for the child by members of different teams and specialities can all have a bearing on how the documentation is completed.

The findings (Chapter 6) demonstrate that when records with no information are brought to the attention of practitioners they are still not completed for days. This could be because the child concerned is one of many seen in A&E and the practitioner may not be able to recall details retrospectively with accuracy. It is also possible that a perception exists that by not completing documentation immediately this will save time. Not only is this unrealistic, but it also does a disservice to the child (DH, 2004; DfES, 2004a). Perhaps if the care of the child was organised more explicitly with the aim of keeping communication of paramount importance, staff may find that this has the effect of reducing the pressure which comes from being focused on the task in hand, thereby treating documentation as being insignificant.

It is the value added by people-context, experience and interpretation that transforms information into knowledge (Davenport and Prusak, 1998). To value something is more than just regarding it as important; therefore our decisions are guided by information learnt from our environment. This information may come via personal experiences but also from the behaviour of others within the same surroundings, thereby influencing our performance (Berger and Luckmann, 1967). The work of Heidegger (1962) suggests that the way people see things and the way they act are all expressions of the way they are in the world.

From the data that has been collected, staff appear to be working in a habitual way as a consequence of watching each other's habits, and it is clear that they see A&E records as part of an object reality. It is also interpreted to mean that experience,

perception and understanding which are used originate from the department's organisational structure. According to the work of Berger and Luckmann (1967) our values are influenced by human symbolic representation; therefore the standards that are passed onto us become representations themselves. A common factor which may influence the value staff put on records, at times could be, that staff may feel that the most important issue is the treatment of the injured child; therefore completing documentation is considered a lower priority. However, this is not an option, as accurate and contemporaneous documentation is a legal requirement and is a vital tool for communication within a health and social environment (GMC, 2006; NMC, 2008; HM Government, 2010).

9.3 The account: The use of A&E records

This research highlights that written records in their existing form are not very child centred. Therefore, they do not provide a design that enables staff to record information methodically. The data from the study also demonstrates noteworthy issues regarding content and accuracy of records which affect the ability of other professionals to execute their safeguarding roles, for example incomplete records. Whilst some people may be highly skilled in providing accurate documentation, others may be significantly handicapped because of inadequate record keeping skills. It is clear from other studies (Dollery, 1971; Alment Report, 1976; Klein, 1982; DHSS, 1983; Maxwell, 1984; Clements, 1995; Klein, 1997; DH, 1998; Scott, 2004; Pullen and Louden, 2006; Audit Commission, 2009) that there are wide variations in record keeping practice across the NHS in the United Kingdom.

The Department of Health's research initiative on child protection (DH, 1995a) focused on inter-agency child protection practice, yet failed to highlight the potential risk of poor documentation as an important factor. The Laming (2003; 2009) reports following the death of Victoria Climbié in 2000, and Peter Connelly in 2007, quite rightly identified that it was essential to improve information sharing. Nevertheless within the documents no effective discussion regarding the issue of ineffective documentation was presented.

What is more, the present study provides additional evidence that staff do not routinely comply with standard 5 of the NSF for children (DH and DfES, 2004b)

and the Trust record keeping policy (2004, Appendix 13). Standard 5 of the NSF for Children (DH and DfES, 2004b) states, as a matter of good practice, staff at all levels need to understand their roles and responsibilities in relation to the safeguarding of children. It is therefore essential that professionals who are at the forefront of care in an A&E department have a good working knowledge regarding child protection (DH, 2004; DH and DfES, 2004b; HM Government, 2010). It is also important to consider what motivates staff, for even if special skills are needed, the current education method that is still predominant in training health professionals, leads to the acquisition of written documentation by absorption of knowledge or ideas through continual exposure rather than methodical learning, and is therefore unhelpful. Consequently, the ability of the professional to provide information to safeguard children is limited. Data from this study also indicates certain failures in compliance to records keeping and /or A&E procedures to reflect best evidence-based safe practice. Therefore, there is a possibility that the members of staff wishing to improve their communication skills are lacking clear guidelines.

The importance of the data in this study has been confirmed by other studies (Taitz et al. 2004; Sanders and Colbey, 2005; Law et al. 2006; Gilbert et al. 2009; Laming, 2009). Those studies have highlighted that the number of child abuse cases reported to the child protection agencies was lower than what would have been expected. The evidence has also been corroborated by a collaborative audit by the Acute Hospital Trust in May 2010, who reviewed 100 child records and identified four main areas where improvement in practice were required. These were: documentation, communication, training and process. Therefore, there is verification that issues relating to documentation are still not being addressed.

According to the National Audit (2011) report, central to achieving the aim of improving services and the quality of patient care, was the successful delivery of an electronic patient record for each NHS patient. However, although some care records systems are in place, progress against plans has fallen far below expectations and the delivery of care records systems across the NHS is nowhere near the completeness of functionality that will enable it to achieve the original aspirations. Munro's (2011) final report on child protection in England quite rightly focuses on early intervention and preventative services. Taken together, when

considering the key areas covered by the recommendations, the report falls short on the issue of documentation.

Communication involves two or more people sharing information (Higgs et al. 2005). Therefore, in the everyday real world of an A&E community, staff are interacting together with a social system formed over some time. Firstly, they are confronted by immediate issues, such as differential power, accountability, time pressures, inexperience and the responsibility of safeguarding children (Parsons 1971; 1977; Loxley, 1997; Payne, 2000; DfES, 2004a; Rivett, 2009; HM Government, 2010; ICHSC, 2011). Secondly, they encounter different groups of people: managers, nurses and doctors from the A&E team, hospital specialists, and colleagues from other health and social environments (Laming, 2003; 2009; ICHSC, 2011). These two contexts illustrate different styles of interaction. Some of which are more role specific than others. Evidence from my study and literature indicate (Stainton Rogers, 1989; Taylor and Field, 1997; Loxley, 1997; Dombeck, 1997) that sometimes it appears that members of staff find these encounters helpful, but at other times controlling. In their response the participants gave the impression that they have adopted certain strategies for dealing with stressful issues and interactions. These strategies seem to range from a continuum of systems to authority and include communication and power, staff passivity-disengagement with the process of assessment, recording, which includes record production, non-adoptive/adoptive approaches to hospital management, and imbalance in professional knowledge (training).

In this study, the issues relate to meanings and truth, therefore, it is difficult to draw explicit lines in practice. The human element, such as staff value and perception of complete documentation, is complex and multifaceted. Hence it has been concluded that in the real world of A&E, with different socially-constructed arrangements and practices, multiple realities exist. Thus, when the importance of the human element on documentation was analysed, the data revealed (Chapter 7), environment and language were so unified that they determined the central theme of the study as being professional communication. So to provide further understanding of the human experience as it is lived, these elements are discussed below.

9.4 Part one - being there-existing in relation to A&E (environment)

This part consists of three spheres: records keeping, knowledge, and responsibility. Nevertheless, whilst the role of documentation was being assessed, the purpose and the balance of these spheres changed fundamentally as reviewed below.

9.4.1 *Records keeping*

The practice of information sharing inevitably starts with the procedure of an assessment of the child, and forms the basis for the involvement by other agencies (DH et al., 2000). For that reason, the process by which a child may be safeguarded is extricably intertwined with the social setting in which it is written. Therefore, the nature and quality of the records depend on a variety of personal, professional and organisational factors, both for the selecting and interpreting of evidence (Munro, 2004b; 2004c; Payne, 2004; Parton, 2006). Hence in practice, where multiple realities exist, record keeping becomes the all-encompassing feature of documentation.

9.4.2. *Knowledge*

In A&E where the assembling, recording and communication of information to others take place, knowledge is an important element in the provision of effective documentation. According to the work of various authors (Polit and Hungler, 1999; Porter, 2002; Denzin and Lincoln, 2005; Polit and Beck, 2010), an important characteristic of the human mind is the ability to recognise regularities, and to make predictions based on our observations. The work of Berger and Luckmann (1967) argues that the social stock of knowledge differentiates reality by degrees. Therefore, our understanding changes and develops according to our experiences and the social context within which we find ourselves. Nevertheless, in the health care system it is generally recognised that status allows for the use of power, Foucault (1980) believes that knowledge is constantly associated with power. He argued that once knowledge is used to regulate the performance of others, it involves control of action. In A&E where policies and procedures are used to regulate practice, they impact on our behaviour; therefore, differential power can shape our professional competence and confidence.

9.4.3 *Responsibility*

It is evident in this study that professional judgement was used in the recording and sharing of information. Under the Children Act 2004 (DH, 2004) all health care organisations have a duty to safeguard and promote the welfare of children. WTSC (HM Government, 2010) places responsibility and expectations on every practitioner to fulfil their safeguarding responsibilities effectively. With responsibility, goes authority to direct and to take the necessary action to ensure that the welfare of children is promoted (DH, 2004; HM Government, 2010). Therefore responsibility is an important factor in the provision of effective documentation, as practitioners are accountable for the care they provide (GMC, 2006; NMC, 2009).

9.5 Part two - models of systems (language)

This part relates to networks of A&E and hospital services as they impact on documentation. Language is a form of representation that is essential to survival, for that reason it plays an important role in the analysis of everyday reality (Vygotsky, 1978; Hacker, 1998;). Because language links knowledge through meanings (Berger and Luckmann, 1967; Vygotsky, 1978; Hacker, 1998), in this project it has enabled me to interpret and understand evidence from the study. According to the work of Berger and Luckmann (1967) because we respond to the stimuli in our environment, standards that are passed on to us become representations themselves. From the data the impression is given that, through mutual observations, A&E staff may have been following a process of habits and customs of the way things were done.

Although I started the study hoping to uncover the story of how A&E child records were used, I found myself torn between the reciprocal roles played by the A&E staff in relation to safeguarding children and the legislation, policy and practice that objectifies documentation in the everyday world of A&E. Different status within the department and inter-disciplinary differences appear to contribute to problems (Samavor and Porter, 1999; Payne, 2000; Hutchings et al. 2003). The data shows that there is a lack of emphasis on the child. This could be because staff are not working in a children's A&E, therefore they are caring for both children and adults so they may not be experienced in child care. As a result, it is possible that staff are

sending and receiving varied messages; therefore, their ideals and everyday practices appear to be in conflict (see Chapter 7). At times they looked as if they may have discovered that they were in a complex and less certain real world in which accountability appeared to push them into a defensive frame of mind (Fish and Coles, 2000; Ferguson, 2004; Mansuri, 2008). Thus, it is possible that they found themselves covering over issues relating to environment and language, thereby posing the potential for them to be less competent practitioners, as their critical awareness could have been compromised.

As a result, they gave the impression that they may then have become overwhelmed and paralysed in the defensive mode, thus having difficulty providing the appropriate documentation as required. They, therefore, struggled to maintain a sense of meaning, feeling both criticised and demoralised. Hence, when they became buried in the defensive mode, they forgot their ideals, lost sight of their place in communicating, and fell victim to apathy and to the circumstance. Consequently, this could mean that the needs of the children are overlooked. Durkheim (1970) argued that in such a situation people find the norms and values around which their lives have been structured are no longer applicable to their current situation. As a result, common values and common meanings are no longer understood and progress does not occur. In this case what appears to be missing is the opportunity to perceive the wider picture of documentation and information sharing that reflects the disparity and contradictions between their ideals and their everyday practices. Therefore, more flexible learning could eventually begin to integrate these two disparate modes (covering over and defensive) into a workable mode of providing effective documentation (see Chapter 8).

A&E is subject to numerous constraints, such as many bureaucratic and rigid rules and set procedures. Consequently the language of interpretation available to its members for these processes has an impact. For it is in the language that their reality is constructed (Berger and Luckmann, 1967). Therefore, because of the language used within this department, the people with power such as managers, doctors, senior nurses, are likely to influence the others. As a result there is likely to be little individual freedom of action. Foucault's (1980) work, along with his ubiquitous analysis, is just the sort of technique that can be related to the provision

of A&E documentation. According to Foucault (1980) knowledge is forever connected to power, and language is related to knowledge in diverse ways. He claims that once knowledge is used to regulate the conduct of others, it entails constraint, regulation and the disciplining of practice.

Hargreaves' (1972) concepts of elaborated and restricted codes or speech systems can be seen to regulate the options that staff in A&E utilise. An elaborated code arises where there is a gap between the speaker and the listener which can only be crossed by explicit speech. In the wider sense, an elaborated code is normally associated with major decision making areas of the social structure. A restricted code arises where speech is exchanged against a background of shared experience. This form of social relationship acts selectively on what is said, when it is said, and how it is said.

Hargreaves (1972) shows awareness of the existence of a variety of cultures and values in society, and points to a relationship between the social structure and a range of linguistic choices. He argues that to acquire dignity a person must achieve a sense of competence, of making a contribution to, and of being valued by, the group to which he or she belongs. So, if you are not part of the group you may feel excluded.

In A&E, where there is a particular management framework and hierarchical structure, language has been deliberately designed to exclude some members. As a result, people use their speech to identify the particular group to which they belong. So people like managers, doctors, and senior nurses, who like to think that they belong to a valuable group, have a direct relation to the question of linguistic prejudices. This is a way that people consider themselves a better group than others, since much stress is placed on senior members of staff and not enough on the duties and responsibilities that the senior members should have towards the entire A&E group. Therefore, in this context people have different levels of linguistic competence and performance which provides the notion of inequality, as people's communicative inequality relates to their experience. Hence, in A&E, where there are social situations, people perform differently because of their knowledge.

According to the work of both Hargreaves (1972) and Bernstein (1972), communication competence is knowledge of language needed by a speaker or hearer to grasp the message effectively. This includes our knowledge or ability to use linguistic forms appropriately. In this study, linguistic diversity has undoubtedly played a crucial role in documentation. For that reason, the codes have become the A&E staff's psychological reality to the extent by which they facilitate or inhibit documentation and information sharing. Because of linguistic diversity A&E policy makers may be faced with complex and sometimes conflicting issues regarding what are considered appropriate ways to provide effective documentation. An important starting point for the members of staff in A&E is the need to be aware of the relevance of linguistic diversity and how it impacts on their work.

It has been suggested by Benjamin (2004) that differential power is the authority's figures whose actions, by virtue of their roles, directly affect the well-being of the other. In an A&E community, managers, doctors and senior care practitioners have the more powerful positions, since status achieved allows the use of power, which varies according to an individual's role, and being deeply structural it is perceived as legitimate. Consequently, differential power is amplified by the physical aspects of practice; hence the psychological effect increases the imbalance of power. Therefore, the concept of power involves both constraints and enablement. If this view was taken and it was constraining, it would have some level of impact on record keeping. However, if it was enabling staff would have the aptitude to act.

9.5.1 *A& E perspective*

If A&E decision making is conceptualised in terms of understanding the purpose and mode of documentation, authentic decisions could be made from the assessment of each situation. Thus practitioners will no longer be forced to justify why practice cannot be changed, so, they will be able to take authorship of their work. Therefore by using the framework proposed (**Figure 8.2**) to look at documentation, they do not have to fall victim to the situation since they initiate and provide their own experience.

9.5.2 *Organisational perspective*

It is clear from this study that documentation and information sharing is affected by staff's behaviour; therefore the situation is multi-faceted and complex. For this reason the mechanical model from the theory of communication (Shannon and Weaver, 1949) which derived from the Sender, Message, Code, Receiver (SMCR) concepts (Chapter 2), over-simplifies the multifaceted nature of documentation and information sharing. As a result, a more realistic model (**Figure 8.3)** that can enhance organisational functions in the process of change through mutual understanding is proposed. Central to this model is the belief that documentation and information sharing involve the social construct people place on record keeping and the perceived associated value of conveying that information to others. We assume the need for shared respect and mutually positive attitudes towards each person in the communication exchange which can lead to joint action towards shared goals, once the communication patterns are known.

9.6 Conclusion

In the day to day world of A&E, members of staff are interacting within a social system that has been formed over a period of time; thus, the method by which records are completed has become habituated. The study has found that documentation and information sharing are inextricably linked to the perceptions, views, and understanding of the A&E staff. Consequently, their subjective and social interpretation, which is a necessary requirement, contributes to the potential reasons why the records are incomplete. The complexity of meanings that are often social, emotional, economic, cultural, political and technical also provides a very difficult challenge. Conflicting social policy and legislation, together with different status in the organisation also cause difficulties. Thus circumstances place restrictions on outcomes, for whilst some multi-professionals understand the implication of their actions and can work as autonomous practitioners, others may respond in different ways. As an example, they may refuse to accept that the records are incomplete and continue to insist that they have performed the task adequately.

In the findings it has been illustrated that short comings begin from the moment a child's history is documented; therefore inaccurate accounts can lead to a child

remaining unsafe or wrongful action being taken. The most important hazard of poor communication between professionals is a risk to children. Consequently, good records/documentation is at the heart of professional practice. The following chapter presents the final conclusion.

Chapter 10 Conclusion

Introduction

The focus of this study is the social construct people place on documentation and the perceived associated value of conveying information within and between social environments. The thesis has sought to explore the use of child records in A&E as a means of improving child protection from the perspective of the staff that use these records. A review of current evidence that underpins documentation has identified poor quality in the recording and sharing of pertinent information. However, whilst the area of safeguarding children is developing with greater focus on better information sharing, which is reflected in major legislation, policy and practice; this has not addressed the importance of the human element on documentation. A gap exists, therefore, in our knowledge of the social construct people have regarding record keeping. What this study does is create new understandings of the way staff in a health and social environment perceive their roles in the selection, recording and communication of information to other colleagues. In so doing it raises new and emerging ideas worthy of further analysis and clarification. Furthermore, a gap in methodological approach is evidenced by the limited body of work focusing on documentation in the child protection arena. To conclude this thesis I present the contribution to knowledge, contribution to practice, strengths, and limitations of the study, recommendations for further research, my reflective journey and a quote from the LSCB (2009).

10.1 Reviewed information

This research draws on the literature reviewed and through a social constructivist approach explores participants' perspectives of the use of child records. It is this examination that constitutes both methodological uniqueness and a contribution to knowledge. The issues in this study relate to meanings and truth, what happens in everyday life, what is recorded and shared and the influential problems concerning the effect and impact of serious child protection occurrences on human behaviour. Thus, in keeping with the social constructivist approach, the research question (Chapter 1) is based on the premise that staff perceptions, views, and understanding of the use of child records may play a critical and instrumental role in the safeguarding of children at risk.

In reviewing the literature two main concepts have been addressed. Firstly, the concept of the social construct people place on documentation and information sharing. Since the 1970's there has been considerable focus on child protection and evidence shows that safeguarding the welfare of children is held to be of paramount importance in the United Kingdom (Laming, 2003; 2009; DfES, 2004a; HM Government, 2010; Munro, 2011;). However, although a substantial body of legislation has been put in place since 2002, shortcomings in record keeping remain, for example, the Children Act (DH, 2004) and the revised WTSC document (HM Government, 2010). Secondly the concept of the use of child records as an instrument in child protection has revealed that, although documentation is seen as a good tool for communication at times, it may be treated as inconsequential. For it is indicated that the influential perspectives, such as A&E everyday routine and treating the injury of the child, may be considered more important.

An examination of the concepts led, in this thesis, to the identification of the interpretive inquiry as being appropriate for the study. Hence, attention was concentrated on the audit of records, focus group discussions and observational data from participants of the study. Evidence supports the notion that the human element is important in documentation, and that the behaviour of staff plays a vital role in the process for safeguarding children. This is because it influences how and what is communicated to the healthcare team and others. The participants were able to conceptualise the idea that their role was crucial, for they were the ones who would be creating and sharing the required information. They felt, since they are responsible and accountable for the documentation and care they provided, that they should be the ones improving the records. Although it is recognised that they relied on organisational processes and procedures, and acknowledged that these are of enormous importance, they also wanted to make their own contribution. They believed that the development of rapport in all relationships is important if communication is to be effective.

In promoting the importance of the human element on documentation and information sharing, it is useful to consider briefly that the A&E world is influenced by different arrangements and practices that may have an effect on staff.

The approaches used in documentation described in this thesis are complex and intricate. Therefore there is a requirement for staff to be given the knowledge and skills (competencies) to identify, develop and recognise the complexities involved in their everyday practice. It is my intention that they are enabled to develop skills to record and convey appropriate data between agencies, thereby promoting the welfare of children. However, it is important for them to keep in mind that by thinking critically they do not always have to be influenced by habits and expectations that constitute their frame of reference.

The overarching research question guiding this project was: 'In order to safeguard children how do staff in A&E and other agencies perceive the use of A&E child records (birth -16 years)?'

I address this question by synthesising data from the case study of the use of A&E records by identifying themes. Five themes and three theme clusters derived from the records, focus group discussions and observational data were integrated into a set of findings. I then related these integrated findings to the literature. The findings were:

The evidence indicates that the A&E staff and other agencies believe that although A&E child records are a good tool to convey information, the records are not sufficiently child focused. As a result, they do not provide a format which enables staff to record information accurately, and is consequential on the attempts of staff to always recognise and identify risks factors. Findings from the study indicated that participants regard structure and process as crucial components required for effective documentation. The research sub questions from the main question demonstrate these points**:**

Sub questions

a) How does the use of A&E child records fit into the wider aims of safeguarding children?

It is generally understood that workers in a health and social environment rely on clinical records as the basis of information about the current status and planned care of a child; therefore the use of A&E child records does fit into the wider aims

of safeguarding children. The results of the study highlight that A&E records are used as the main source of communication with regards to the safeguarding of children. This identifies with the key tool in safeguarding the health and wellbeing of a child since the information could alert a clinician to possible risk factors that are likely to affect their welfare, therefore the records fits in at the micro, meso and macro levels (see Chapter 4). (1) Micro level - A&E records specify a care pathway in order that children's rights and potential vulnerability are not overlooked (DH and DfES, 2004b). (2) Meso level - accurate and well-kept records provide the essential underpinning to good child protection practice (DH and DfES, 2004b). (3) Macro level – the ethos behind the sharing of records is to encourage partnership working and improve communication leading to enhanced continuity of care (HM Government, 2010). However, in this study due to issues regarding content and accuracy, there are certain failures in compliance to record-keeping and/or A&E procedures to reflect best evidence-based safe practice for example, record keeping policies and procedures for safeguarding children. Findings from this study have also been used to inform the research framework for the next study in the safeguarding children series (Atkinson, 2010; Martin et al. 2010).

b) To what extent do A&E staff and other agencies value and share A&E records to help safeguard children?

A&E staff and other agencies value and share A&E records to help safeguard children, because the records are considered a good tool for communication. Nevertheless the result of the study reveals that written records in their present form do not provide a format that enables staff to record information comprehensively. A&E staff and other agencies consider that the structure of child records is an inherent part of a good record, providing specific areas for recording clinical details vital for the protection of a child. Members of staff felt that in order to enhance and promote the welfare of children, the records could be improved if there were provision to provide a full and comprehensible history.

c) What knowledge is there of the purpose and use of A&E child records?

The data shows that some members of staff identify the purpose and use of A&E child records as the main source of information for safeguarding children. Nonetheless, difficulties arise from the lack of emphasis on the needs of the child, and highlight situations where there are unrecognised signs of the child's needs. What is reported to be a problem on admission is different in final documentation, as a result the sharing of information is poor and subsequently no action is taken, thus responsibilities for safeguarding children are being undertaken inappropriately and ineffectively. The evidence indicates that this could be related to the influence of routine or everyday assessment in which the child presenting to A&E may be seen as a succession of different categories of cases, rather than as a person. The findings also reveal that the purpose and use of child records could be shaped by the ability of staff to understand the relevance of safeguarding and promoting the welfare of children. The evidence also shows that within the A&E environment the staff relate more easily to the basis of the social structure, an indication is given that the concept of the purpose and use of child records is oriented towards the way in which they interpret their experiences, in turn, this is influenced by habits and expectations that constitute their frame of reference.

d) What evidence is available to show how and why A&E child records are actually used?

Some members of staff understand how and why child records were actually used. However, for others key skills and knowledge of how and why these records are used is required. For where a full and comprehensible history is important, the needs of other readers are not always taken into consideration. Hence it is possible that meanings may not be the same in the minds of others who share the information the records contain. As a result of issues such as illegible handwriting and abbreviations, much of the information required to safeguard a child is inaccessible to other colleagues involved in their care. Therefore even though the originator may understand what has been written, difficulties may still arise when other professionals are involved in the information sharing process. Consequently, a major difficulty may be created in obtaining the appropriate information upon

which to make an informed decision, as a result the required assessment may not be possible.

e) What are the implications for practice of the findings of this research?

The findings from the study highlight the following implications for practice. (a) Written records in their present form do not provide a format that enables staff to record information comprehensively, as a consequence there is a lack of emphasis on the needs of the child. (b) The ability of the professional to provide information to safeguard children is limited; consequently poor communication between professionals is a risk to the children. (c) Poor documentation, non-compliance with processes and procedures and inaccurate accounts can lead to a child remaining unsafe or wrongful action being taken. The findings indicate that the A&E process should be re-modelled from the procedure in **Figure 8.1.** Therefore the recommendation was that the new model in **Figure 8.2** should be introduced to ensure that children at risk can be identified; accordingly the records have since been redesigned.

This study into A&E staff and other agencies perception of the use of A&E child records (birth - 16 years) is underpinned by the research question; therefore, the records, focus group discussions and observational data provided rich information to enable a number of findings. In addition, the findings from the subsidiary questions point to the perceived intentions of conveying that information to others and the importance of understanding the social construction placed on documentation. This is in keeping with the tenets of naturalistic research, that in the social world, the associated meaning of things shapes how people act, subsequently this influences the way staff operates in an A&E department.

The findings of the research are a clear demonstration that the standard of documentation and information sharing relate to the social construct people place on record keeping. These findings have implications for workforce development both locally and nationally and for commissioners and providers of health services aiming to improve children’s health and wellbeing.

10.2 Contributions to knowledge

This work is original, because what this study does is create new understandings of the social construct placed on documentation and information sharing. It applies an ecological approach and provides a methodology for understanding how staff in a health and social environment perceive their roles in selecting, recording, and communication of information to other colleagues. It also attributes meaning to the data and observed behaviour and addresses how standard procedures for documentation and information sharing are influenced by the human element. Other studies that emanated from the literature review were not in-depth and public inquiries focused mainly on process issues, standardisation, protocols, and procedures. Thus this thesis contributes to the growing body of knowledge in information sharing in the child protection arena.

In the social world, the associated meaning of experience, knowledge, power and status shape how people act, subsequently this influences the way staff operate in an A&E department. The result of this research suggests that the work of Berger and Luckmann (1967) and Heidegger (1962) is appropriate for considering the need for staff in a health and social environment to obtain ways of acquiring control of the authorship of the records. The outcome of the research is also a clear demonstration of the importance of the human element in documentation and information sharing. Therefore, the findings have implications for both the practice of safeguarding children and workforce training.

10.2.1 *On the conceptual level*

The creation and sharing of records is undertaken by services such as A&E for formal functions of recording and communicating information to others. Therefore, the nature and quality of the records depends on a variety of personal, professional, and organisational factors both in the selection and on interpreting of evidence. In this study, equal emphasis is given, not only to the perspectives of the diverse staff who share the records, but also to their environment, and interactions.

10.2.2 *Models*

In order to provide structure for the models (**Figures 8.2 and 8.3)** Colaizzi's (1978) approach was utilised. However, although his work provided a framework with

guiding principles for the analysis of data common features across his model only worked on single dimensions. As a result his method did not provide a holistic structure that presented conclusions where the validity was patently clear. For that reason some modifications of his model were required in order to go beyond what a person said into the realm of interpretation. Therefore, a contribution to knowledge was made by combining Colaizzi's (1978) model, and the hermeneutic circle (Heidegger, 1962), to provide a blend of approaches (**Figure 5.9**) thereby providing rigour for the analysis.

The model in **Figure 8.1** demonstrates how the process for documentation and information sharing currently works. The proposed models in **Figures 8.2 and 8.3** show how the participants in my study believe the process ought to work. Therefore, the models in **Figures 8.2 and 8.3** does advance our understanding of the inter-relationships in the documentation and information sharing process that have received little attention and is my contribution to knowledge. These models also provide information that underlines the mechanisms behind social processes and for making judgements about the possible transferability of the findings to other settings. Evidence (DH, 2000; DH, 2011) indicates that A&E departments in the United Kingdom are similar. Therefore, the model in **Figure 8.2** can be adapted by any A&E department to suit their particular situation.

Although it may be a challenge for professionals, educators, and policy makers within the child protection area, documentation could also be improved by combining the models in **Figures 8.2 and 8.3** with the HBM model (Chapter 4). This in turn would assist in the task of encouraging staff to mesh with the goals of the HBM in order that their values and perceptions could be improved. Thus this could influence important referents of the social construction that appear to have a strong impact on standard procedures for records and record keeping, thereby enhancing documentation.

10.2.3 *Processes and procedures*

The findings of this study indicate that programmes for information sharing and documentation deal with issues of process, standardisation, protocols and procedures. For that reason, focus should be on good teaching strategies, which are

important to make the value of documentation and information sharing more meaningful for others. Subsequently, the complexities and ambivalences in human relationships that are obligatory for clinical workers, such as routines, ought to be simplified, for example, by using flow charts and/or updated clear pathways.

10.2.4 *From the pragmatic perspective*

The ecological theory posits that unlike most behavioural and psychological theories, it focuses on inter-relation transactions between systems. It also stresses that all existing elements within an ecosystem play an equal role in maintaining balance of the whole. Therefore, this investigation makes a new contribution to the conceptual understanding of the use of records by those involved in the task; as inter-relationships, processes, structures and issues that may arise come together and overlap in this study (**Figure 4.3**). Therefore the results have important implications for constructing effective communication programmes for enhancing documentation and information sharing. For those reasons this study contributes to the existing ecological theory.

10.3 Contributions to professional practice

10.3.1 *Contributions to professional practice locally*

- As an outcome of the study, the immediate stakeholders agreed the following: A&E child records were to be restructured with a clearly identified single page dedicated to addressing safeguarding issues (see e-mails **Appendix 19**);

- Records have since been reformatted new design shown in **Appendix 36**;

- This study has demonstrated the value of the PLHV's role when integrated into an A&E department;

- Strategic inquiries, such as a collaborative audit (Chapter 6) and discussions on the subject between the PCT (Provider and Commissioning) and the Acute Hospital Trust are on-going;

- This research is also embedded in the on-going audit of the A&E department concerned and is informing further development.

10.3.2 *Contributions to wider professional practice*

- The implementation of the model in **Figure 8.2** would ensure that more children at risk can be identified when they attend A&E. For this to happen, this model should be promoted in all hospital's A&E departments in the United Kingdom as it can be modified for each particular situation. This could be achieved by utilising a pilot study approach that evaluates issues relating to implementation, staff perceptions of problems, obstacles and suggestions for improvement;

- With this model accurate analysis of the child's needs can be made as all of the information required to protect the child can be obtained, therefore, a greater safeguarding impact will be achieved;

- The outcome of this research demonstrated the value of the PLHV's role in this particular environment, therefore, it is recommended that all hospitals in the UK should have a PLHV as safety measure.

10.4 Strengths of the study

The present study is qualitative and as such did not rely on having a statistically representative sample. By using both Colaizzi's (1978) approach and the hermeneutic circle (Heidegger, 1962) a combination of meanings was provided that were articulated through the interpretive process. Therefore, the strengths lie in the contextually rich data generated from audited records, focus groups and observational data which were used to address the value placed by staff on documentation and information sharing

10.5 Limitations

According to the work of authors in the field (Crabtree and Miller, 1999; Mays and Pope, 2006), there are several limitations to the qualitative approach. They also imply that the findings from an in-depth qualitative research are rarely superficial. The sampling size in this study was small, because it was driven by the research design to create and test new interpretations and not by the need to generalise or

predict. There are also potential problems with human subjectivity, because members of staff in A&E and the LOCP group were used as the instrument through which information was gathered. Whilst these practitioners are extremely intelligent and sensitive, they are also fallible as a tool and therefore could distort what they would like to believe is reality.

The subjective nature of the study is a further potential limitation that may give rise to questions about and the personal nature of the conclusions. In other words, it is difficult to know if two naturalistic researchers studying the use of child records in the same A&E department would arrive at the same results.

In this study I have made explicit the account, the theoretical framework and methods used at every stage of the thesis, explained the context clearly, illustrated and given reasons for the sampling strategy, described the fieldwork taken in detail, explained clearly and justified theoretically the procedures for data analysis. As the researcher I acknowledge that there is no one 'truth' about the phenomena (use of A&E child records) that it is merely an examination of the numerous interpretations of the use of these records made by the participants of this research. The fact has also been recognised by the researcher that in this situation there are limitations; however, evidence from the study indicates that there are genuine concerns[46] regarding documentation and information sharing.

According to Norman (1970) and Gummesson (2000), the outcomes of the research can be transferred if the circumstances are similar. Therefore, in the situation where A&E departments in the UK are comparable, I suggest that findings of this research can be transferred to a similar environment to that which it was undertaken. Nevertheless, in other circumstances the reader will be able to evaluate the applicability of the research outcomes to other contexts (e.g primary care services for children to provide early identification of problems and the promotion of physical health and emotional wellbeing). Due to the opportunities that this thesis allowed, this research focused only on the use of child records generated in

[46] See **Appendix 37** letter from Liaison/Child Protection Co-ordinators Swansea

an A&E department in one location; hence, there was no provision for any further investigations concerning child records generated in other departments.

10.5.1 *Discussion of the study limitations and how these might be addressed in the future.*

The aim of this study was to investigate staff in A&E and other agencies perception of the use of A&E child (birth - 16 years) records**.** As the researcher, I recognise that much is poorly understood about why documentation and the sharing of information continues to be an issue in the field of child protection. Therefore, I am striving to understand the multiple aspects associated with the safeguarding of children. Originally this was not an action research project, nonetheless the immediate stakeholders appreciated the quality of the research, therefore the records have been reformatted with a clearly identified single page addressing safeguarding issues, channels of communications with other professionals responsible for safeguarding children were initiated and the research is now embedded in the on-going audit of the A&E department concerned.

In the future the primary aim of the study could be the improvement of child care by means of written A&E documentation. Therefore an action research study could be conducted to make improvements not only to the situation in practice, but also to practitioners understanding of issues regarding the safeguarding of children. Thus the study could be maximally useful and reflect and reveal different aspects of reality, as the action research process would allowed me to evaluate the results of changes that are introduced, reflect of any consequences or issues following the changes; enabling me to plan further action that would be beneficial to the welfare of children. In addition, the research question could be grounded in the experience of children who attended the A&E department in order to understand the use of A&E records from their perspective. Also an attitudinal survey of perceptions could be used to identify professional standpoints, and other variables influencing the creation and sharing of relevant information on children.

10.6 Recommendations for future research

Further research with a wider cross section of departments that share children's information within the public, private and voluntary sectors is now required. A number of emerging issues have highlighted gaps in knowledge which would be worthy of further/new research, these are:-

- Exploration of documentation when different teams and specialities are caring for the child to determine whether the findings can be applied in different settings (eg. minor injuries unit, G.P. surgeries, walk in centres);
- A comparison of the differences between information recorded in A&E when the child speaks for itself and when parents speak on his/her behalf;
- Examination of how data can be collated and monitored to better protect children when multiple sources of emergency care are used by parents;
- Investigation to explore if there is a better way of combining paper based and computerised record keeping to accurately identify children at risk.

10.7 Key points

Evidence in this study indicates that existing records have the potential to be a good tool for communication; however, risk factors are not always recognised or identified, and the records are insufficiently child focused.

The research has allowed me to:-

- Improve documentation locally;
- Identify children at risk;
- Open channels of communication with other professionals responsible for safeguarding children;[47]
- Attribute meaning to the data;
- Construct a conceptual framework for improving the process of documentation when a child attends A&E;
- Create a new understanding of the social construct placed on documentation.

[47] See **Appendix 37** letter from Liaison/Child Protection Co-ordinators Swansea

10.8 Dissemination

So that my contribution can become part of the safeguarding community and add value to A&E documentation and information sharing, I have shared this knowledge with others by:-

- Making both formal and informal presentations at A&E and LOCP meetings, as an on-going process, during and after data collection[48],[49];
- Disseminated the messages from my research to a wider audience by poster[50] presentation at the Community Practitioners and Health Visitors Association (CPHVA) Partners in Health Professional Conference 2006, Anglia Ruskin University Second Annual Research Student Conference 2008,[51] at the Hospital concerned (poster permanently displayed) and by Journal publication (Forge 2010)[52];
- As a member of the Community Practitioners and Health Visitors Association (CPHVA), I intend to make further presentations and oral reports at professionals' conferences that are attended by clinicians from the area of child protection. This gives me an opportunity to meet and communicate with others who have experienced the same or similar problems in different parts of the country;
- Further Journal publications.

10.9 Reflective journey

Probably like every other PhD student doing qualitative research, I have struggled with questions relating to ontology (the nature of reality), epistemology (knowledge of that reality), axiology (what is the role of values in the inquiry), and methodology (the particular ways of knowing about that reality). In my research study I have also wrestled with my role as a researcher and academic, grappled with my own subjectivity and struggled to evaluate the relevance of my research. I reflect on how, at one point, I discovered by going through the data, that the initial coding system was incomplete. This meant, without an effective coding system, it

[48] See **Appendix 38** disseminating information - letter from - Managing Director
[49] See **Appendix 38** disseminating information - letter from Director of Quality and Nursing
[50] See **Appendix 38** disseminating information - Poster - Safeguarding Children at Risk
[51] See **Appendix 38** disseminating information - Bulletin June 2008, Volume 5 - News
[52] See **Appendix 38** disseminating information – In touch – Spring 2010, Issue five - News

was not possible to integrate important themes adequately. This proved to be an important lesson, because making changes midway through was a painful and frustrating experience. In this case, it was necessary to re-read all previously coded material in order to gain a complete grasp of the situation. As a researcher, I also understand that self-reflection or self-criticism is an active part of interpretation; therefore ethics and responsibility have guided me every step of the way.

In undertaking this project, a key question for me was, in order to provide effective documentation, is control by differential power (doctors, managers, lead nurses) required, or is it possible for all practitioners to be empowered? Using the new framework in my project to analyse the importance of the human element on documentation, provided me with an answer to the question. It is recognised that in an area of work such as child protection where the process is difficult and complex things may sometimes go wrong. Nonetheless, the most effective safety net is prevention; therefore, it is essential to look at how we can create documentation where record keeping and information sharing can be more effective. Hence, it is proposed that if improvements could be made to written documentation this could assist in enhancing outcomes for all children, thereby providing the delivery of a more cohesive service.

Reflection on and analysis of the social constructivist approach has led to an initiation of new knowledge that can have an impact on the way that the issues of documentation and information sharing are addressed. During this interpretative study I have concluded that people do not have to allow themselves to fall victim to circumstances, for they can create their own reality and therefore they should affect their reality by taking appropriate action. According to the work of both Berger and Luckmann (1967) and Heidegger (1962) we create and re-enforce reality, both subjective and objective. As I started my thesis by revisiting the care of Peter Connelly, the final words from my reflective journey must come from my thoughts of him, as I recalled one of the A&E participant's response to the research question:

"*Something that concerns me on the front of the records is that we have accompanied by and the usual, we need to know who that person is. A name and*

the relationship to the child as well. Making sure that the person who is with the child especially if they have another name has the responsibility to authorise that treatment. We need to know who this person is before we treat."

And as established in the case of Peter Connelly the LSCB Executive Summary (2009) states:
"It is reasonable to conclude that for a case which reflected the highest level of concern that we have for a child's welfare, the interventions were insufficiently focussed on the children's welfare" p.24, paragraph 5.1.

10.10 Finally

Finally, the major benefit of this research is improved documentation which has opened up channels of communication with others within the area of safeguarding children and has actually enhanced a process which is likely to identify more children at risk.

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APPENDIX 1 Research proposal

ANGLIA RUSKIN UNIVERSITY

Institute of Health & Social Care

Director of Studies:

Second Supervisor:

Independent Referee:

Internal Referee:

Proposal for Registration of this project for the degree of PhD

Title -: THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

Investigator: JOYCE.A.FORGE
MSc. BSc. (Hons) RN. RM. RHV. F.P.Cert.

Date of submission January 2007

PhD Research Proposal

Context
The following project arises from a small study conducted in December 2002, involving 15 participants from the A&E multi-professional team of an acute hospital in Essex. The study at the time asked why children's health and social care records were not available to meet the needs of a critical incident concerning child protection. This local evaluation prompted fundamental questions about the functions of the sharing of child records in A&E.

The ethos behind the sharing of A&E records was that it would encourage partnership between multi-professionals, improve communication leading to enhanced continuity of care. This ethos is echoed in Standard 5 of the *National Service Framework for Children, Young Persons and Maternity Services* (DH 2004) and the *Working Together to Safeguard Children document* (DH 2006). These national guidelines state that the welfare of children must always be regarded as of primary importance as their age and potential vulnerability renders them powerless to protect their own interest, and further states that it is vital that special safeguards are put in place to monitor the quality of paediatric services.

This research seeks to study in-depth staff use of child records in A&E in order to understand the challenges associated with the sharing of these records by diverse professional staff and other agencies in one location. Reliable, accurate, complete, up to date, and secure information is believed to be critical to the delivery of effective care that can protect vulnerable children who present to emergency services.

Focus of the study – The use of child records in Accident and Emergency (0-16 years)

Aims of the study
To elicit A&E staff and other agencies perceptions of the use of child records in one A&E department (in one location).

Background
The prevention of accidents is identified as one of the key areas in the Government's public health strategy *Saving Lives: Our Healthier Nation* (DH 2000). According to the Child Accident Prevention Trust (CAPT), 2 million children every year are taken to an A&E department after having had an accident. Botting (1995) and CAPT (2005) provide further evidence that accidental injuries are known to be the single largest cause of death among children after the age of one and the single leading cause of disability in the United Kingdom.

In 1995, the key child protection message specified by the government was a new emphasis on ensuring that all children are safeguarded, supported and protected (DH 1995). In addition, the Laming report (2003) argues that those children with the greatest need are a particular issue for A&E departments. It notes an association
between some child deaths that have occurred following attendances at A&E departments, minor injuries units or walk in centres because they were missed at the early stages due to the absence of information sharing and record keeping systems

(Laming 2003).

From past inquiries into deaths of other children as well as more recent cases, there are striking similarities, which indicate that some of the issues are long standing. The goal of minimising the incidence of death and serious harm to children from abuse has not yet been achieved. According to Laming, the common threads, which led in the case of the death of Victoria Climbie were a failure to intervene early enough, poor co-ordination between public services, the absence of anyone with a strong sense of accountability and a failure to share information. Laming states:

> *"There was a consistent failure by doctors and nurses at both hospitals to record information comprehensively, to record shared concerns, and to record and complete the actions that the concerns prompted, worst of all, nobody noticed when things were not being done."* (Health analysis 11 paragraph 11.5, Laming 2003*).*

Based on the *Working Together to Safeguard Children document* (DH 2006), the NSF Standard 5 (DH 2004) specifies a care pathway through services such as A&E in order that children's rights and potential vulnerability are not overlooked. A&E departments are in the front line of care, and staff are in a position to be able to respond to the needs of vulnerable children. In considering the background to the intended study it is necessary to review the policy background, which informs issues of record and record keeping.

The National Service Framework for Children (DH 2004) stipulates that in order to safeguard children information needs to be brought together from a number of different sources and careful judgements made on the basis of this information. It further states that well-kept records provide the essential underpinning to good child protection practice. Good record keeping is not only an important part of the accountability of professionals to children, it can also make professionals less vulnerable, can prevent a disservice to children, can help to focus work, and assists with the continuity of care. It is argued that well-kept records provide essential tools for work to be monitored and is important for peer review. Overall, the principles of effective record keeping advocate that records are clear, concise, accessible and comprehensive. Judgements made, actions and decisions taken should be carefully recorded. It is stated that where decisions have been taken jointly across agencies or endorsed by a manager this should be made clear. These guidelines also point out that relevant information about a child, which leads to any intervention should include history of the child, nature of any intervention including outcomes, the means by which change is to be achieved and any progress that is being made. In accordance with NSF Standard 5, records should be factual and be stored safely so that they can be retrieved promptly and efficiently (DH 2004).

The issue of shared records has been found to be invaluable in contributing to injury prevention and appropriate use of scarce resources (*Preventing accidental injury*, the CMO's response, DH 2002). Treating injuries costs the National Health Service (NHS) £2 billion a year and the consequences of injuries received in the home cost £25 billion a year. The 1999 White Paper '*Saving Lives: Our Healthier Nation'* (DH 2000), made injury prevention a priority. The difficulty is that for

preventative action to be effective it must be coordinated across a variety of agencies and requires record keeping.

Record keeping is not only critical to the safeguarding of children. Record keeping is also an integral part of nursing, midwifery and health visiting, as it underpins clinical practice. It is a tool of professional practice and one that supports the care process. The Information sharing and Assessment (ISA) programme (DfES 2006) and the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC 1996 now the Nursing and Midwifery Council (NMC) supports the principle of shared records.

According to Armstrong (1996), the history of protecting children from abuse has illustrated on many occasions the importance of good record keeping. She introduces poor record keeping by illustrating that the picture one may have of the issues surrounding the safeguarding of children may at times be severely restricted by the nature of the record keeping. She argues that in most cases this may not be a problem. However, there may be medical and non-medical information that is relevant to a child's safety. Therefore, where children are concerned, it may be vital that a fuller picture is necessary in order to ask the right questions and make the right decision.

The writer has conducted a comprehensive search to establish if this particular topic has already been researched, including approaching the professional organisations for literature, policies, guidelines, standards, information, tools for any similar project in England. Although a number of results containing child records in A&E were found, research into issues such as how do child records in A&E protect a child is scarce. This provides a good example of the limited understanding about the sharing of A&E records within a particular professional framework.

Research Question
How do staff in A&E and other agencies perceive the use of A&E child records (birth -16 years)?

Epistemological Framework
This research sits within an interpretive paradigm (Lincoln & Denzin 2005). In other words, the proposed study seeks basic data about knowledge of the purpose and use of children's (0-16 years) A&E records.

One cannot presume to know at the outset what the perceptions, views and understanding of the use of child records in A&E are when diverse staff share the information these records contain. The research itself will question the concept and the use of child records in A&E as a vehicle to improve child protection from the perspective of the diverse staff that use these records. Using a reflective qualitative case study (see methodology below), the research will advance both understanding and experiential knowledge about the use of child records in one A&E department.

Using a case study methodology that derives from an epistemological framework (Stake 2005), the researcher will seek to uncover the story of how A&E child

records are used by means of the process of the research itself. This research does not attempt to generalise beyond the case study site but it does seek to establish internal validity.

Conceptual Framework

Case studies can refine theory (e.g., the theory that the use of child records in A&E is a vehicle for the safeguard of children considered to be at risk). In order to understand the subject itself, my research will address issues and assumptions about (a) the nature of child protection work; (b) the presumption that child protection can be improved by the use of shared record keeping; (c) the presumption that staff in A&E and other agencies perceive child record keeping as a vehicle for the safeguard of children; and (d) presumptions that records are fit for the purpose of safeguarding children. These are examples of concepts that this research will interrogate.

Methods

The study will be carried out in three stages.

Stage 1 –For one 24-hour day a month on different days each week over a period of six consecutive months (26 weeks) all records will be analysed. Using a researcher's checklist for data collection the criteria for analysing these records will be standard 5 of the National Service Framework for Children (DH 2006) and the Trust record keeping policy. There will be two categories of records (a) those indicating no cause for concern beyond the medical needs of the child and (b) those indicating cause for concern and the need for action: those records with concerns will be analysed. They will be divided into two groups (a) identified by members of staff in A&E and (b) those identified by the liaison health visitor. Auto Data will be used to support the data collection task. This will be the basis for finding out (a) what is in child records; (b) how they are being used; (c) what readers do with the information; (d) who they are shared with. In other words, evidence of input, use and output.

Stage 2

A focus group of 10-12 drawn from 120 members of A&E staff from the case study site will be selected. This purposive sample, representing each category of staff will be asked to address the question, "How and why do we use child health records?" By using a focus group, the researcher will seek to gain insight into the collective perceptions and opinions of how and why child records are used in A&E.

Stage 3

A focus group of 10-12 members of the local operational child protection group (representatives from outside agencies) will be asked the same question. This focus group will be used to obtain information about opinions and perceptions of child records in A&E, their contents and use.

From the actions in stages one, two, and three, qualitative data will be obtained which will provide an in-depth and detailed understanding of the use of child records in A&E.

Both the focus groups will be facilitated by the researcher with an impartial focus group supporter present who will take notes. Each group will last up to one hour. They will be arranged to take place at a convenient location in a formal setting booked in advance to avoid interruptions. At the case study site, for practical reasons, the focus group will be arranged following negotiation with the A&E managers for early morning, taking shift patterns into consideration. The focus group for the local operational child protection members will be arranged following negotiation through the Chairperson to take place during a working day, date and time convenient to members. All information will be kept in accordance with the Data Protection Act 1998.

The rationale of the research, the methods and the intended outcomes will be explained to all participants and organisations collaborating with the work in a written information sheet. A written statement of the aims, rationale, methodology and intended outcomes will be produced and used as a means of informing participants. Consent will be acquired in writing by the researcher facilitating the focus groups prior to the meeting. Focus group consent forms will be sent out with letters of invitation and a participants' information leaflet. Participants who are willing to participate in the focus group will be asked to complete and return consent forms via the internal mail.

Sample
A purposive sample (a) 10-12 A&E staff members (b) a further 10-12 members of the local operational child protection group (outside agencies). This total number is deemed appropriate for a qualitative study of this scale.

Data Analysis
The Qualitative data framework will be used to build up separate descriptions of described events and views by the A&E multi-professional team and outside agencies. It will also be used to identify patterns of response in an attempt to understand the dynamics surrounding the use of children's A&E records in one location. NVivo software will be used to support analysis.

Ethical Statement
Adopting a case study approach implies involvement with members of staff in the A&E department (case study site) and outside agencies in one geographic location. Although my presence in A&E is only a small part of my working day and there is no familiarity between myself and the A&E staff, it is recognised that this could be perceived as a conflict of interest. Therefore provision is made for an impartial observer to be present, at the focus groups, who will take notes.

The very nature of the research and the methodology adopted require the following tasks: (a) approval from Essex 2 Research Ethics Committee and (b) additional approval for registration from the relevant Research and Development Department. The rationale of the research, the methods adopted and the intended outcomes will be explained to all of the participants and organisations collaborating with the work. A written statement of the aims, rationale, methodology and intended outcomes will be produced and used as a means of informing participants. Confidentiality will be protected. Written consent will be requested from all participants. Without this consent, materials will not be used. At all times the

rights of the individual and the multi-professional team in A&E and outside agencies will be protected. All participants will also be informed that if information is given that contravenes their professional code of conduct; I am obliged to inform their line manager (International Council for Nurses 1996 & Royal College of Nursing 2006).

Justification for level of award

Most of the information reviewed from published works, books and journals has indicated descriptive accounts with no depth of research into the perceptions of why child records are used in A&E departments. Nor has there been research into the potential for discontinuity of understanding about the potential role of child records for the purposes of safeguarding children. Information about this subject has not been probed. The proposed study will make an original contribution to the conceptual understanding of the use of child records by those involved in the task and issues that may arise. The contribution or not of record keeping to the quality of service provision for children attending A&E has been assumed but has not been studied from the perspective of the users of these records. Information sharing by means of A&E child records as an instrument in child protection where non-accidental injury is present has not been addressed before.

Communication of findings

The investigator plans to communicate the findings from this study verbally and in writing with the A&E multi-professional team and stakeholders where the study is to be conducted. The researcher also anticipates presenting the findings at research conferences, in particular local as well as national research conferences. The study findings will also be developed into an article for submission for publication.

Plan of study

Task	2006	2007	2008	2009	2010-2011
Ethical approval		February			
Literature review	November	Continuing	Continuing	Continuing	Continuing
Stage 1		February to August			
Stage 2 Stage 3		September to October			
Data analysis			Continuing	Continuing	Continuing
Writing up Thesis				Commence writing up	Complete

APPENDIX 2 Research Training Certificate of attendance

Hospitals NHS
NHS Foundation Trust

Certificate of Attendance

presented to

Joyce Forge

RESEARCH TRAINING

GOOD CLINICAL PRACTICE AND RESEARCH GOVERNANCE

22 FEBRUARY 2006

3 hour session

.....

Research Facilitator
Course Organiser

APPENDIX 3 A&E staff participants information leaflet

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

Participant information leaflet for A&E staff

Dear Colleague

I would like to invite you to take part in this research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

Why is the study being done

- The national guidelines 'Working Together to Safeguard children' (DH 2006) states that the welfare of children must always be regarded as of primary importance as their age and potential vulnerability renders them powerless to protect their own interest.

- The proposed study seeks data about knowledge of the purpose and use of children's (0-16 years) A&E records.

- The purpose is to study in-depth staff use of records in order to understand the challenges associated with the sharing of A&E child records by diverse professionals

- The study will therefore make an original contribution to the conceptual understanding of the use of child records in A&E by those involved in the task and issues that may arise. The contribution or not of record keeping to the quality of service provision for children attending A&E has been assumed but has not been studied from the perspective of the users of these records.

- The research study I am undertaking has been approved by Essex 2 Research Ethics Committee and the University Hospitals Research and Development Group.

- The research is the basis for my doctoral study in Health and Social Care.

Who am I

- I am a paediatric liaison health visitor employed by the PCT and I am the researcher. I will carry a PCT identification badge. You are advised to ensure you have confirmed my identity before participating in the focus group. An impartial person employed by the PCT will also be present during the focus group discussion.

- I will spend some time explaining about the process of the focus group discussion before it begins to make clear what is expected. Maintaining confidentiality is extremely important throughout the study and will be a 'ground rule'. All information gained will be confidential.

What will your involvement be?

- As you are a member of the A&E staff I am asking if you would participate in this study. This will be a focus group involving other colleagues and will be used to obtain information about opinions and perceptions of child records in A&E their contents and use.

- You will have the opportunity to explain in depth your views and perceptions on the use of children's (0-16 years) A&E records, and so contribute to modes of effective record keeping that can better serve children presenting to emergency services.

- Permission to tape record the discussion will be requested prior to the focus group from all participants to gain an accurate record of the discussion. The tape recorded discussion will be later transcribed.

- If you agree to participate in the focus group and are willing to allow quotes taken from the discussion to be included in any written work produced from the study, please complete the participant's consent form and return it in the self addressed envelope provided via the internal mail. Any quotes used will be anonymised and you will not be identified from these quotes.

- All information collected from the focus group discussion, including any tape recordings, will be kept strictly confidential in accordance with the Data Protection Act, 1998.

How and when will the focus group discussion take place take place?

- The focus group discussion will last up to 1 hour giving everyone the opportunity to discuss in greater detail their views and opinions regarding the use of children's (0-16 years) A&E records. For practical reasons the focus group meeting will take place at a convenient location in a formal setting booked in advance to avoid interruptions. It will be arranged following negotiation with the A&E managers for early morning taking various shift patterns into consideration.

Confidentiality

- All information that is disclosed during the focus group discussion will be treated with strict confidentiality. However, if anything is disclosed that affects the well-being of children or is detrimental to professional practice I am obliged to inform your line Manager, who will investigate and action accordingly in line appropriate Trust policies.

What if you choose not to take part?

- Taking part in this research study is completely voluntary. Deciding not to take part will not make any difference to you as a professional.

- There is no clinical intervention or withdrawal of care so therefore no negligent harm is anticipated, but as a Trust employee indemnity cover is provided by NHS indemnity HSG (96) 48.

- There are no special compensation arrangements or indemnity for non-negligent harm available under the NHS indemnity HSG (96) 48.

What if you are unhappy following the focus group Discussion

- Your line manager or another member of the A&E multi-professional team would be able to advise you. Alternatively if you prefer to discuss your dissatisfaction with someone independent a member of the clinical effectiveness unit at the Hospital would be able to advise you, the Local NHS Patients Advisory Liaison Service (PALS), or NHS complaints mechanism -Julie .

Thank you in advance for agreeing to take part in the study and for providing me with the information.

Your views and opinions are very important in order to identify mechanisms that will ensure modes of effective record keeping that can better protect children presenting to A&E

APPENDIX 4 PARTICIPANT INVITATION LETTER TO ALL MEMBERS OF THE MULTI-PROFESSIONAL TEAM A&E

Date

Dear colleague

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

As part of my PhD studies in Health and Social Care I am exploring the use of child records in A&E. This is to identify modes of effective record keeping that may have the ability to better protect children presenting to emergency services. In line with this aim, the focus will be on perceptions and opinions of staff on the use child records in A&E.

I am writing to invite you to participate in a focus group. Enclosed is an information leaflet for you to read. Confidentiality will be assured on all matters that are included in the focus group.

If you agree to participate in the focus group please complete the consent form enclosed and return to me in the self-addressed envelope provided. On receipt of this I will contact you with details of the time, place and venue for the focus group meeting.

.
Should you wish to discuss the matter further please do not hesitate to contact me on Pager No: Telephone :

Liaison Health Visitor

APPENDIX 5 LOCP participants information leaflet

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

Participant information leaflet for the Local Operational Child Protection Group

Dear Colleague

I would like to invite you to take part in this research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

Why is the study being done

- The national guidelines 'Working Together to Safeguard children' (DH 2006) states that the welfare of children must always be regarded as of primary importance as their age and potential vulnerability renders them powerless to protect their own interest.

- The proposed study seeks data about knowledge of the purpose and use of children's (0-16 years) A&E records.

- The purpose is to study in-depth staff use of records in order to understand the challenges associated with the sharing of A&E child records by diverse professionals.

- The study will therefore make an original contribution to the conceptual understanding of the use of child records in A&E by those involved in the task and issues that may arise. The contribution or not of record keeping to the quality of service provision for children attending A&E has been assumed but has not been studied from the perspective of the users of these records.

- The research study I am undertaking has been approved by Essex 2 Research Ethics Committee and the University Hospitals Research and Development Group.

- The research will be the basis for my doctoral study in Health and Social Care.

Who am I

- I am a paediatric liaison health visitor employed by the PCT and I am the researcher. I will carry a PCT identification badge. You are advised to ensure you have confirmed my identity before participating in the focus group. An impartial person employed by PCT will also be present during the focus group discussion.

- I will spend some time explaining about the process of the focus group discussion before it begins to make clear what is expected. Maintaining confidentiality is extremely important throughout the study and will be a 'ground rule'. All information gained will be confidential.

What will your involvement be?

- As you are a member of the local operational child protection group I am asking if you would be willing to participate in this study. This will be a focus group involving other colleagues and will be used to obtain information about opinions and perceptions of child records in A&E their contents and use.

- Please find enclosed a willingness to participate consent form. On receipt of this form from the participants, a sample will be selected using a table of random numbers so you may or may not be randomly selected. If you are selected in this process you will be invited to participate.

- You will have the opportunity to explain in depth your view and perceptions about the use of children's (0-16 years) A&E records, and so contribute to modes of effective record keeping that can better serve children presenting to emergency services.

- Permission to tape record the discussion will be requested prior to the focus group from all participants to gain an accurate record of the discussion. The tape recorded discussion will be later transcribed.

- If you agree to participate in the focus group and are willing to allow quotes taken from the discussion to be included in any written work produced from the study, please complete the participant's consent form and return it in the self addressed envelope provided via the internal mail. Any quotes used will be anonymised and you will not be identified from these quotes.

- All information collected from the focus group discussion, including any tape recordings, will be kept strictly confidential in accordance with the Data Protection Act, 1998.

How and when will the focus group discussion take place take place?

- The focus group discussion will last up to 1 hour giving everyone the opportunity to discuss in greater detail their views and opinions regarding the use of children's (0-16 years) A&E records. For practical reasons the focus group will take place at a convenient location in a formal setting booked in advance to avoid interruption. It will be arranged following negotiation through the Chairperson to take place during a working day, date and time convenient to the members.

Confidentiality

- All information that is disclosed during the focus group discussion will be treated with strict confidentiality. However, if anything is disclosed that affects the well-being of children or is detrimental to professional practice I am obliged to inform your line Manager, who will investigate and action accordingly in line appropriate with policies.

What if you choose not to take part?

- Taking part in this research study is completely voluntary. Deciding not to take part will not make any difference to you as a professional.

- There is no clinical intervention or withdrawal of care so therefore no negligent harm is anticipated but cover is provided by NHS indemnity HSG (96) 48.

- There are no special compensation arrangements or indemnity for non-negligent harm available under the NHS indemnity HSG (96) 48.

What if you are unhappy following the focus group Discussion

- Your line manager or another member of the A&E multi-professional team would be able to advise you. Alternatively if you prefer to discuss your dissatisfaction with someone independent a member of the clinical effectiveness unit at the Hospital would be able to advise you, the Local NHS Patients Advisory Liaison Service (PALS), or NHS complaints mechanism.

Thank you in advance for agreeing to take part in the study and for providing me with the information.

Your views and opinions are very important in order to identify mechanisms that will ensure modes of effective record keeping that can better protect children presenting to A&E

APPENDIX 6 PARTICIPANT INVITATION LETTER TO ALL MEMBERS OF THE LOCAL CHILD PROTECTION GROUP

Date

Dear colleague

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

As part of my PhD studies in Health and Social Care I am exploring the use of child records in A&E. This is to identify modes of effective record keeping that may have the ability to better protect children presenting to emergency services. In line with this aim, the focus will be on perceptions and opinions of staff on the use child records in A&E.

I am writing to invite you to participate in a focus group. Enclosed is an information leaflet for you to read. Confidentiality will be assured on all matters that are included in the focus group.

If you agree to participate in the focus group please complete the consent form enclosed and return to me in the self-addressed envelope provided. If you are randomly selected to participate I will contact you with details of the focus group.
.
Should you wish to discuss the matter further please do not hesitate to contact me on Pager No:. Telephone:.

Liaison Health Visitor

APPENDIX 7 Consent form for focus group discussion

RESEARCH PARTICIPANT WILLING TO PARTICIPATE IN FOCUS GROUP CONSENT FORM

Title of Project: **THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF**

Name of Researcher : Joyce Forge

Please initial box if you agree

1.I confirm that I have read the participant information leaflet dated------- and agree to participate in this study as a member of the accident and emergency team/local child protection group. ☐

2. I understand the research study will focus on the use of child records in A&E and I have had the opportunity to ask questions. ☐

3. I understand that I will participate in a focus group along with other colleagues and the group will be asked about their opinions and perceptions of the use of child records in A&E. ☐

4. I understand that the focus group will be tape recorded and later transcribed. The data will be kept safe and secure in accordance with the Data Protection Act 1998 and my identity will not be linked to my response therefore I will not be identified from raw or published material. ☐

5. I understand I have the right to decide voluntarily whether to participate in the study and have the right to terminate my participation at any point. Deciding not to take part will not make any difference to me as a professional and my development will not be affected. ☐

6. I agree to participate in the focus group and I am willing to allow quotes taken from the discussion to be included in any written work produced from the study. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

APPENDIX 8 Letter to participants who were not selected for the study

LETTER TO PARTICIPANTS VOLUNTEERING TO TAKE PART IN THE STUDY BUT WHO WERE NOT SELECTED

Date

Dear Colleague

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY AS A VEHICLE TO SAFEGUARD CHILDREN: THE PERSPECTIVES OF STAFF

Thank you for volunteering to take part in this study and for taking the time to send back your signed consent form. However, you were not randomly selected and so your participation will not be needed on this occasion. When the study is finished I would be happy to send you a summary of the results of the study.

Should you wish to discuss the matter further please do not hesitate to contact me on Pager No:. Telephone:

Liaison Health Visitor

NHS
East of England
Essex 2 Research Ethics Committee

Telephone
Facsimile:

15 March 2007

Mrs J.A Forge
Paediatric Liaison Health Visitor

Dear MRS FORGE

Full title of study: **The use of Child Records in Accident and Emergency**
REC reference number: **07/Q0302/19**

Thank you for your letter of 26th February 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair in consultation with the Lead Readers for your study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	Version 5.3	22 January 2007
Investigator CV		22 January 2007
Protocol	Version 2.0	26 February 2007

07/Q0302/19

Covering Letter		26 February 2007
Covering Letter		22 January 2007
Peer Review		
Interview Schedules/Topic Guides	Version 2.0	25 February 2007
Letter of invitation to participant	Version 2.0	25 February 2007
Participant Information Sheet: A&E Staff	Version 2.0	25 February 2007
Participant Information Sheet: Local Operational Child Protection Group	Version 2.0	25 February 2007
Participant Consent Form: for Focus Groups	Version 2.0	25 February 2007
Response to Request for Further Information		
Letter from Dr		28 September 2006
Letter to Dr		18 September 2006
Email from		02 October 2006
Letter from ARU		17 January 2007
Checklist for the Analysis of Child Records in A & E	Version 2.0	25 February 2007
Letter to participants	Version 2.0	25 February 2007
Participant Invitation Letter	Version 2.0	25 February 2007

R&D approval

You should arrange for the R&D office at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final approval from the R&D office before commencing any research procedures.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/Q0302/19	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mr
Chair

Email:

Enclosures: Standard approval conditions

APPENDIX 10 Checklist for the Analysis of Child Records in A&E- Age 0-16 years

Criteria: Children's NSF DH 2006 & Trust Record Keeping Policy

Q1. Details present in health record	
DATE OF BIRTH	ETHNIC GROUP
SEX	MODE OF TRANSPORT
POSTCODE (FIRST 3 DIGITS)	NO. OF PREVIOUS ATTENDANCES
ACCOMPANIED BY (RELATIONSHIP)	DATE **&** TIME SEEN BY PROFESSIONAL
DATE AND TIME OF ARRIVAL	
DATE **&** TIME OF INCIDENT/ ACCIDENT	
NEXT OF KIN/RELATIONSHIP	

Q2. Is there legible history?				
YES		**NO**		**PARTLY**
Q3. Is the record complete				
Fully		**Not at all**		**PARTLY**
Q4. Is a cause for concern identified on the record?				
YES		**NO**		
If answer is Yes proceed with analysis. If answer is No Did health visitor liaison identify a cause for concern				
YES		**NO**		
If answer is Yes proceed with analysis. If answer is No - no further analysis.				

Q5. Were arrangements made for follow up appointments or continuing care from other supporting services?

YES

NO

Q6. Is any referral to specialist practitioners or other agencies recorded?

YES

NO

If yes, please indicate where/who referred to
GP

PAEDIATRICIAN

Other Hospital/Tertiary Centres

SOCIAL SERVICES

SPECIALIST UNIT

HEALTH VISITING SERVICES

CHILD PROTECTION UNIT

SCHOOL NURSING SERVICE

CHILD & FAMILY CONSULTATION SERVICES

PRIMARY HEALTH CARE TEAM

Who referred?

Member of staff	Specify
Health Visitor liaison	

Q8. Outcome of A&E attendance

ADMITTED

REFERRED

DISCHARGED WITHOUT INTERVENTION

TREATED AND DISCHARGED

Q9.NATURE OF RISKS (CRITICAL FACTORS)?	
▪ DELAY IN PRESENTING FOR TREATMENT	
▪ HISTORY INCONSISTENT WITH INJURY	
▪ FREQUENT ATTENDANCES	
▪ INJURY IN NON-MOBILE CHILD	
▪ ANY GENITAL INJURY/PROBLEM	
▪ ANY OTHER CONCERNS	

Free Text – Cause for concern/ comments

APPENDIX 11 Transcript stage one of the study

AUDIT OF THE

'Content & Accuracy' of

CHILDREN'S A & E RECORDS

At the Hospital Trust by the

PAEDIATRIC LIAISON

January 2008

AUDIT LEAD

JOYCE FORGE
PAEDIATRIC LIAISON HEALTH VISITOR

REPORT BY

CLINICAL EFFECTIVENESS & AUDIT FACILITATOR

CONTENTS

The following report is a summary of an audit of the presentation and content of children's records in the A & E department at the Hospital, on the morning following the child's attendance to A & E. The audit was carried out during the period 1st May 2007 and November 5th 2007 by the Paediatric Liaison Health Visitor PCT, and follows on from previous audits carried out in 2003 and 2006 on similar records but looking at different criteria.

This audit does not look at the on-going problems surrounding the 'Availability of Record' to the PLHV which was the subject of the previous audits.

BACKGROUND

The Paediatric Liaison service exists to safeguard and promote the welfare of all children. Part of the role of the Paediatric Liaison Health Visitor is to:

- Facilitate effective liaison and communication between all services involved in the care of children who attend the hospital and their families, ensuring continuity of

care, with special reference to child protection, child development and supporting parents.

- Raise awareness of public health issues and primary health services available to children and their families.

The Liaison HV is responsible for notifying Health Visitors and School Nurses of the attendance at Accident and Emergency of children who have sustained an injury whether intentional or non-intentional. She also facilitates forwarding of hospital inpatient and discharge information for children to professionals working in the community. Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. The role of the Paediatric Liaison Health Visitor is to improve communication between Health Visitors, School Nurses and hospital staff. Based at H-block, the Paediatric Liaison Health Visitor is on the spot to visit the ward(s) and feedback patient progress to relevant community-based professionals. Improved communication between the hospital and community nursing staff ensures continuity of care for the patient.

Information sharing is vital to safeguarding and promoting the welfare of children and young people. Sharing information is essential to enable early intervention to help children, young people and families who need additional services to achieve positive outcomes, thus reducing inequalities between disadvantaged children and others. A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.

Shortcomings in working to safeguard and promote children's welfare were brought into the spotlight with the death of Victoria Climbié and the subsequent Inquiry. The Inquiry revealed themes identified by past inquiries, which resulted in a failure to intervene early enough. Failure to share information was one of these recurring themes identified.

AUDIT METHODOLOGY

Agreed custom and practice locally dictated that all records of children (0-16 years) attending the A&E department in the previous twenty-four hours are routinely placed in a special drawer labelled Paediatric Liaison Health Visitor (PLHV). The PLHV assesses the content of these records daily and is required to provide accurate, relevant and timely feedback to community professionals in order that children considered to be at risk can be offered appropriate support.

The average number of children between the ages of 0-16 years old attending A&E is 63 per day. For one 24 hour day a month for six consecutive months (26 weeks) on different days of the week a total of 378 out of a likely total of 2646 or 15% of records were audited.

The Audit commenced on 1st May 2007 and was completed on November 5th 2007.

Two categories of records were chosen (a) those indicating no cause for concern beyond the medical needs of the child and (b) those indicating cause for concern and the need for action; those records with concerns were audited. These records were divided into two groups (a) identified by members of staff in A&E and (b) those identified by the liaison health visitor.

STANDARDS

Records for all children attending A & E must be made available to the Paediatric Liaison Health Visitor on the following working day.

Standard	Target	Exceptions	Definitions/ Instructions
Details present in records of children attending A & E • **Date of Birth** • **Sex** • **Postcode** • **Accompanied by** • **Next of Kin** • **Date & Time of Arrival** • **Ethnic Group** • **Mode of Transport** • **Number of Previous attendances** • **Date & Time seen by Professional** • **Date & time of Incident/Accident**	**100%**	**NONE**	

No exceptions noted. However for Safeguarding issues there are clearly some details which for the PLHV are more significant than others, namely 'Number of previous attendances' & 'Date and Time of Incident/Accident'.

Anecdotal evidence suggests that the records that tend to go missing are for the more vulnerable children – e.g. children transferred to other specialist hospitals.

There is no acceptable level of missing records, and hence the target of 100%.

RESULTS

A total of 2646 children were recorded as having attended the A & E department between 1st May 2007 and 5th November 2007 of these 15%(378) of the records were audited.

Of these

- 93% **did not have** a record of the Date & Time of Incident/Accident
- 100% recorded the Number of previous attendances

The results are illustrated below:

Chart 1 shows the **Proportion** of the details present in the **73** records.

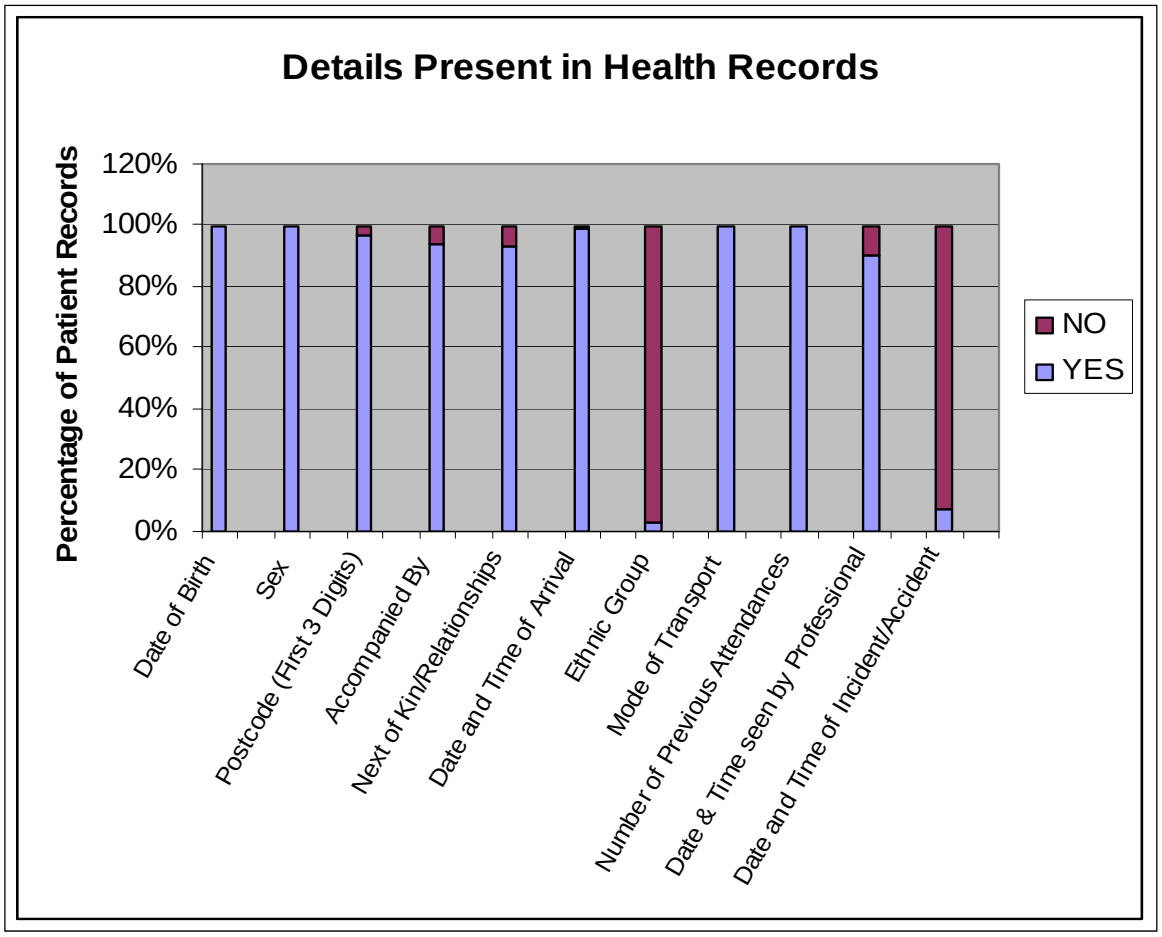


Chart 2 shows the **Number** of the details recorded in the **73** records

	YES	**NO**
Date of Birth	**73**	**-**
Sex	**73**	**-**
Postcode (First 3 Digits)	**71**	**2**
Accompanied By	**69**	**4**
Next of Kin/Relationships	**68**	**5**
Date and Time of Arrival	**72**	**1**
Ethnic Group	**2**	**71**
Mode of Transport	**73**	**-**
Number of Previous Attendances	**73**	**-**
Date & Time seen by Professional	**66**	**7**
Date and Time of Incident/Accident	**5**	**68**

COMMENT

It is noted that in every case the '**Number of Previous Attendances'** was recorded – this is excellent.

Unfortunately, in 68 of the 73 cases, the **'Date & Time of Incident/Accident'** was not recorded. This is of concern. One of the recommendations of the Laming Report was that this should be recorded to enable the monitoring of issues such as 'Late Presentation' of an injury. Any delay in presenting is a failure to meet the child's needs. In some cases it may be that parents are not accessing GP services appropriately and in others the reasons may range from lack of knowledge to neglect. Whatever the reason for the delay, the assessment as to the needs of the child cannot be made if the information on the date & time of the incident is not recorded in the first place.

'Ethnic Group' The Children Act 1989 Sec 22(5)(c) requires that when making a decision in respect of a child that consideration is given to the child's religious persuasion, racial origin, & cultural linguistic background as the child's ethnicity allows a further description of the child just as much as with age & sex. It may or may not give rise to a particular need but alerts the Practitioner to such a possibility.

In this audit – only 2 of the 73 had ethnicity recorded.

Standard	Target	Exceptions	Definitions/ Instructions
Is there a legible history	100%	NONE	-Based on NSF for Children, DofH 2006 & PCT & H Record Keeping Policy, Esseence of care benchmarking, & generic medical standard from Royal College of Physcians
Is the record complete	100%	None	-Based on NSF for Children, DofH 2006 & PCT & H Record Keeping Policy, Esseence of care benchmarking, & generic medical standard from Royal College of Physcians

Is a cause for concern identified on the record	**100%**	**NONE**	**-Based on NSF for Children, DofH 2006 & PCT & H Record Keeping Policy, Esseence of care benchmarking, & generic medical standard from Royal College of Physcians**

No exceptions noted. From a Safeguarding viewpoint all these standards are crucial but the most significant is whether a cause for concern has been identified on the record by staff in A&E.

RESULTS

Chart 3 shows the **Proportion** of the 73 records where the history was legible, &/or the record complete, &/or where a cause for concern was identified.

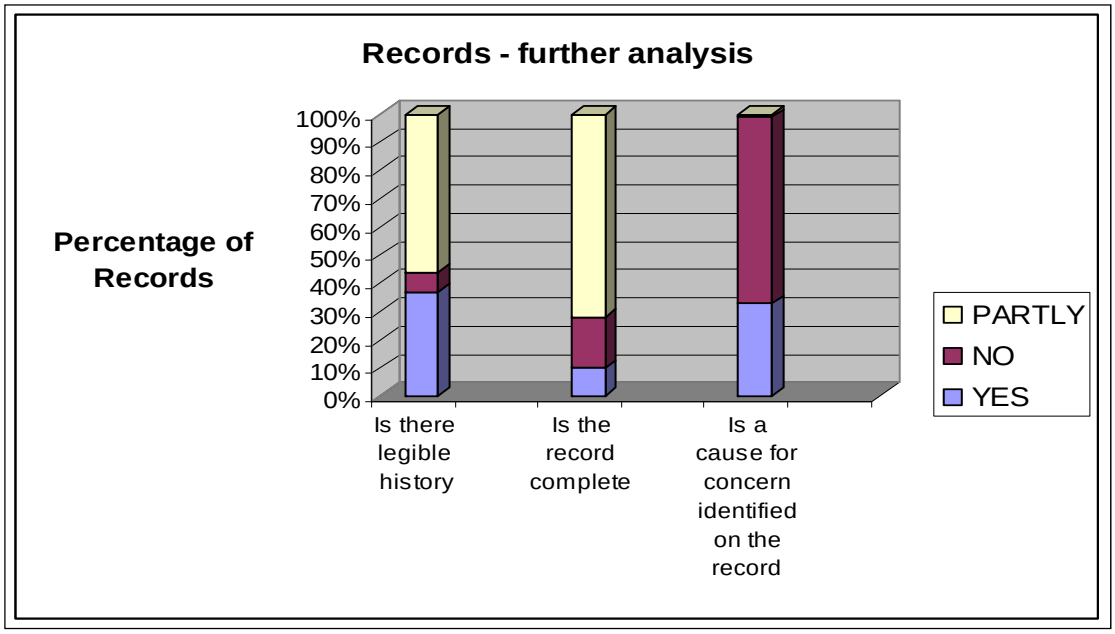


Chart 4 shows the **Number** of the 73 records where the history was legible, the record complete and where a cause for concern was identified

	Yes	No	Partly
Is there legible history	**27**	**5**	**41**
Is the record complete	**7**	**13**	**53**
Is a cause for concern identified on the record	**24**	**48**	**(1 form not completed i.e. just an empty folder with the child's name on)**

COMMENT

All the 73 records that were selected for audit were selected because the LPHV identified a cause for concern. Unfortunately, only 24 of the records indicated that a cause for concern had been identified by the A&E staff.

Of the 48 records where **'No cause for concern was identified'** (as shown in Charts 3 & 4)……

Key Finding

- **47 of the 73 records audited were identified by the PLHV as children where there was in fact a 'cause for concern' but the A & E staff had failed to highlight it.**

This is of concern. The role of the LPHV, as intended by the PCT & in line with the recommendations of the Laming report, is to be a 'safety net' only. It is contrary to safe & effective practice for the PLHV to be the main/primary source of highlighting a case to be 'one of concern' and then for onward referral to the necessary agencies.

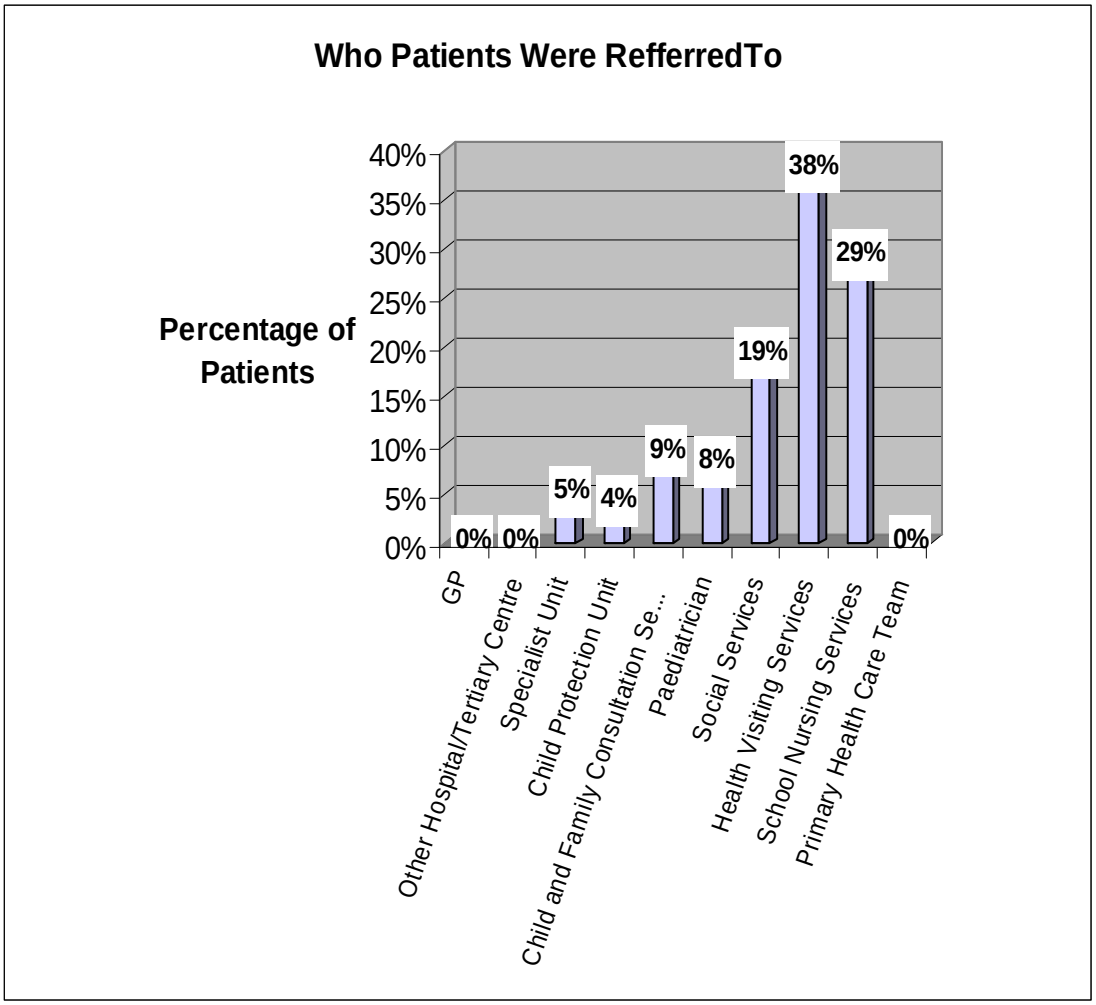
Good, safe professional practice, in line with the Laming recommendations are that the referrals should be made by the Healthcare Professional who has examined the child & can make an appropriate referrals based on medical & non – medical indications such as distress, demeanour, family & any other indications which usually cannot be made after the event.

In addition, the fact that the records are sometimes not legible or complete, only increases the difficulty for the PLHV, and then subsequently whoever the case is referred to make sense of them – therefore there are cases where there is insufficient information to decide what the appropriate action should be because of the content & accuracy of some of the records.

Other Findings

- Where the record was complete and/or a cause for concern identified on the records, 67 had follow up appointments/or referrals to specialist practitioners or other agencies recorded & 4 did not.
- Of those 67 cases where referrals were deemed necessary, 47 of these were made by the PLHV and not the A&E staff.

These 67 referrals were made to…



Key Finding

Of those referred -

- **47 - Were referred by the PLHV**
- **20 - by H staff**

COMMENT

The National Safeguarding Standards - state that **the professional who actually attends to the child should make the referral**. Not only does this ensure that there is an efficient, accurate handover that avoids misunderstandings & discrepancies but crucially, parents are aware that a referral has been made. In addition the professional actually attending the child has the full picture in regard to the demeanour, distress & any other non-medical indications of the child and family.

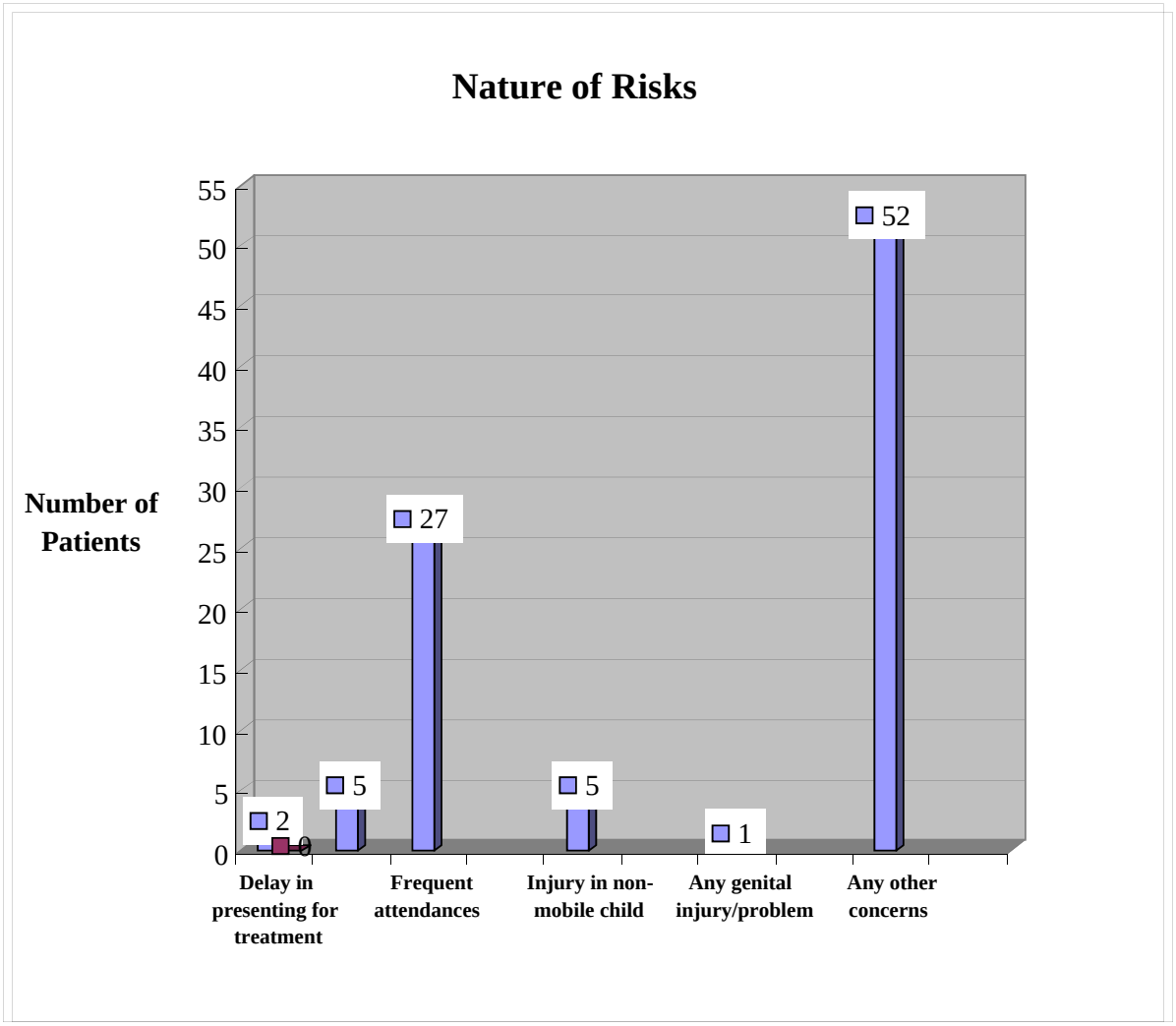
Outcome of A&E Attendance

Children who were identified as at risk by the PLHV & A&E staff

Admitted	Referred	Discharged without Intervention (i.e. No evidence to say any action taken)	Treated and Discharged (i.e. No evidence to say any action taken)
8	14	13	43

Nature of Risks

Of the 73 children who attended A&E and were identified as at risk, the natures of the risks are listed in the chart below.



COMMENT

Delay in Presenting for Treatment – it may well be that these are families who need support as there be a failure to ensure access to appropriate medical care or treatment. Although this is significant for the general population, it is particularly so for the transient population as evidenced by the circumstances surrounding the case of Victoria Climbe. In addition this figure cannot accurately be assessed as in only 5 of the 73 cases were the 'Date & Time of Incident/Accident' recorded

Frequent Attendances – these should be closely monitored. It could be the case that some of these children should have gone to their GP but there could also be some safeguarding issues.

Injury in Non- Mobile Child – Always needs to be addressed & a full history is essential in every case to enable an assessment to be made as to whether the details supplied by the parents/carers tally with the injury/incident. In the cases audited and from anecdotal evidence provided by the PLHV a full history is not usually recorded.

CONCLUSIONS

- The findings of the Laming & other enquiries show that for effective measures to Safeguard children's health well being it is crucial for accurate timely information to be shared as individual incidences by themselves which may seem inconsequential in the first instance may well be viewed differently but when looked at in the round.
- This report highlights significant issues around the content & accuracy of the Child records is A&E at H which impact on the ability of the PLHV to fulfil her safeguarding role as a 'Safety Net' for children who may be at risk of harm
- The audit results also indicate certain failures in record keeping/and or A&E procedures (or compliance to such procedures) to reflect best evidenced based safe practice - thus failing to substantiate that measures are in place to ensure that the interests of children who attend A&E are routinely safeguarded

Addendum to main Audit Report

Since this audit was completed there have been further developments regarding the on-going issue of the PLHV's Access to Child A&E records which are the subject of continuing enquiries/discussions between the PCT (Provider & Commissioning) and the acute hospital Trust.

APPENDIX 12 Transcript stage two of the study - Focus Group 10th July 2007 (Verbatim) LOCP participants

Present:
Impartial person- note taker (NT)
Researcher (R) Joyce
Senior nurse with supervisory duties (SN)
Health visitor with additional nursing skills (HVP)
Senior nurse with both managerial and supervisory responsibilities (TL)
Senior nurse with additional nursing skills specialising in school nursing (SN1)
Senior nurse specialising in school nursing (SN2)
Safeguarding Doctor/General Practitioner (SD)
Assistant with clerical duties (CSW)
Senior nurse mental health unit with managerial responsibilities (MHN)
Management from social services (SC)
Community practitioner specialising in child health (HV2)
Community practitioner specialising in child health (HV1)
Community practitioner specialising in child health with additional nursing skills (HVC)

Sometimes the doctor's writing is very hard to read and we need to be able to do this accurately in order to follow up on the information. The other thing that causes problems at times is the abbreviations used, please could you request that these be avoided (SN1)

I am not only expressing my own views but also those of my colleagues. We all feel that they are a good thing but there are times when we have difficulties to understand the illegible hand writing (HV1).

The information is not clearly documented, and it is not always clear who is present with child in A&E. For example if teenagers, age of friend or indicate who accompanies them (TL).

Forms not received, page at back – not completed – which would be most appropriate to complete, e.g. box relating to concerns. I have spoken to the other G.P's most reported do not receive these records. All they receive is a brief letter which does not give enough information. We feel it would be helpful to receive these records. It would be helpful if the page at the back is completed with the most appropriate information e.g. box relating to concerns. Most reports mainly only seen from the front page, not seen page at the back (SD).

Number of attendances – i.e. if over 4 there should be automatic referral to safeguarding team (SN).

Health Visitor will normally contact family to offer support – parents are not always aware that information has been shared with the Health Visitor (HVP).

They are useful but they do not include no action plan/care plan" (HV2).

We do feel that the person booking the children in should always check the school attended as sometimes this is obviously wrong, for example, a 14 year old with a primary school (HVC).

Mental Health Unit - communication of admission scant (MHN)

For the few that we receive, they are not clearly documented, cannot distinguish who is taking history or in what order. Information in some instances are unclear, unknown abbreviations are used, writing are sometimes illegible (SC).

Without more training child focus will not occur. Dr T. identifying training in Junior Doctors (SD)

Need some initiative and getting practitioners to think about risks/vulnerability (CSW).

Training for Junior Doctors (change at 6 months) needs to be carried out each time (SD).

Summary-participants identified the importance of effective communication. Primarily they considered that A&E records were a good tool for communication. However, effective communication relates to documentation, they therefore highlighted the need for training as shortcomings in documentation can lead to difficulties for another agency/professional.

APPENDIX 13 Transcript stage three of the study - Focus Group 10th August 2007 (Verbatim) A&E staff

Present:
Impartial person - note taker (NT)
Researcher (R) Joyce
Senior nurse with managerial responsibilities for children (SN)
Paediatrician - medical specialist concerned with the diagnosis, treatment and overall care of children (SD)
Senior nurse both managerial and supervisory responsibilities (NM)
Senior nursing roles and are involved in direct care of children (SGN1)
Senior nursing roles and are involved in direct care of children (SGN2)
Tasks are delegated to them by senior nurses who are involved in direct care of children (JN1)
Tasks are delegated to them by senior nurses who are involved in direct care of children (JN2)
Departmental tasks are delegated by senior colleagues (CSW)
Departmental tasks are delegated by senior colleagues (DA)
Departmental tasks are delegated by senior colleagues (RS)

I think we need a little bit more information on the front of the records a tick box would help staff to remember what needs to be included, as S- was saying previously a tick box would help us to remember what is needed. We should I think have the GP and health visitor down as well things like that. The tick box thing may be would help staff. A tick box would help staff. This could be used for adult as well as children (NM).

I've had one recently where a child came in with a drunk lady. The children lived with the father. She said she had access but it turned out they pop in every now and then. She didn't have formal access. There was nowhere to put this on the card (JN2).

Do you think it would help if reception staff got the triage nurse to see the child first and write a triage first this would help? (RS)

The reception just writes unwell child even when the child is blue and black. Do you think we could get this information before they come in rather than the history of child being unwell? (DA).

There is a question of prioritising, a child may have a broken arm broken in three places by the father but when listed as a broken arm it will come after anyone having a heart attack (SGN1).

Queries within a timescale or trigger after set number of attendances-Computer generated e.g. King's standard information included on form of attendance (SGN2).

Something that concerns me on the front of the records is that we have accompanied by and the usual, we need to know who that person is. A name and the relationship to the child as well. Making sure that the person who is with the child especially if they have another name has the responsibility to authorise that treatment. We need to know who this person is before we treat (SD).

"You ask people who they are and where they live but nobody asks the child. You should put the mother and father they live with. Sometimes the mother brings the child in but the child lives with the grandparents. It's something we don't ask the child. Some of them are in foster care but do come in with parents during access (SN)

I think when there are problems there needs to be a quicker way to deal with the records, I always get the feeling that it needs more urgent attention. It always happens out of hours it always happens at weekend , it always happens at nights is there somewhere I can write urgent without writing it about twenty times or whatever (JN2)

We need some way of getting the old cards. You can only read some of the information on one of the records, which is why we need tick boxes and to write it on the front of the card (JN1).

A lot of needs for retraining. We need to check information each time they check in. Check the address, as who they are and not just go on the previous screen and just click yes (JN2).

Summary-These participants focused their attention on incomplete documentation. They were concerned that existing records did not provide a formula to enable staff to record comprehensive information.

APPENDIX 14 Letter to A&E Manager

25th May 2006

Dear Mr.

Re -The use of Child Records in Accident and Emergency

I am writing to ask if you would assist me by agreeing for this project to take place in the A&E department

The proposed study seeks basic data about knowledge of the purpose and use of children's (0-16 years) A&E records. The purpose is to study in-depth staff use of records in order to understand the challenges associated with the sharing of A&E child records by diverse professionals.

Although all members of staff will be invited to participate only 10-12 willing volunteers would be selected for a group interview at one A&E multi-professional meeting. The interview question will be "How and Why do we use child health records? The group will be used to obtain information about opinions and perceptions of child records in A&E their contents and use.

The participants will have the opportunity to explain in depth their collective views and perceptions on the sharing of children's (0-16 years) A&E records. In order to ensure modes of effective record keeping that can better serve children presenting to emergency services.

The outcome of this study will form part of my postgraduate studies in Health and Social Care.

Yours sincerely
Joyce Forge
Paediatric Liaison Health Visitor.

Cc Service Manager Accident and Emergency Department

Appendix 15 Permission from A&E Manager

NHS

Item 25:

Staff Participation Line Management Agreement

Trial Name:

THE USE OF CHILD RECORDS IN ACCIDENT AND EMERGENCY

Lead Investigator at

JOYCE FORGE

Date consent requested:

24/5/06

Signature of Line Manager:
I hereby agree to allow staff within my department to participate in the above trial, subject to further approval of Hospitals NHS

Please could completed form be returned to:

Research Governance Office
Clinical Effectiveness Unit
Postgraduate Centre
Hospital

Appendix 16 Letter to Sub-Director Emergency Care

18th September 2006

Dear Dr.

Re - Child Records in Accident and Emergency

I wrote to you in January 2006 asking for your support to carry out a proposed questionnaire in the Accident and Emergency department to which I had your support, since then I have been advised by my academic supervisors to change the questionnaires to one focus group, also the title of the project will now be the Use of Child Records in Accident and Emergency. I am writing to ask if you will still support this project.

The proposed study seeks basic data about knowledge of the purpose and use of children's (0-16 years) A&E records. The purpose is to study in-depth staff use of records in order to understand the challenges associated with the sharing of A&E child records by diverse professionals.

Although all members of staff in A&E will be invited to participate only 10-12 willing volunteers would be selected for the focus group at one A&E multi-professional meeting. The research question will be "How and Why do we use child health records? The group will be used to obtain information about opinions and perceptions of child records in A&E their contents and use.

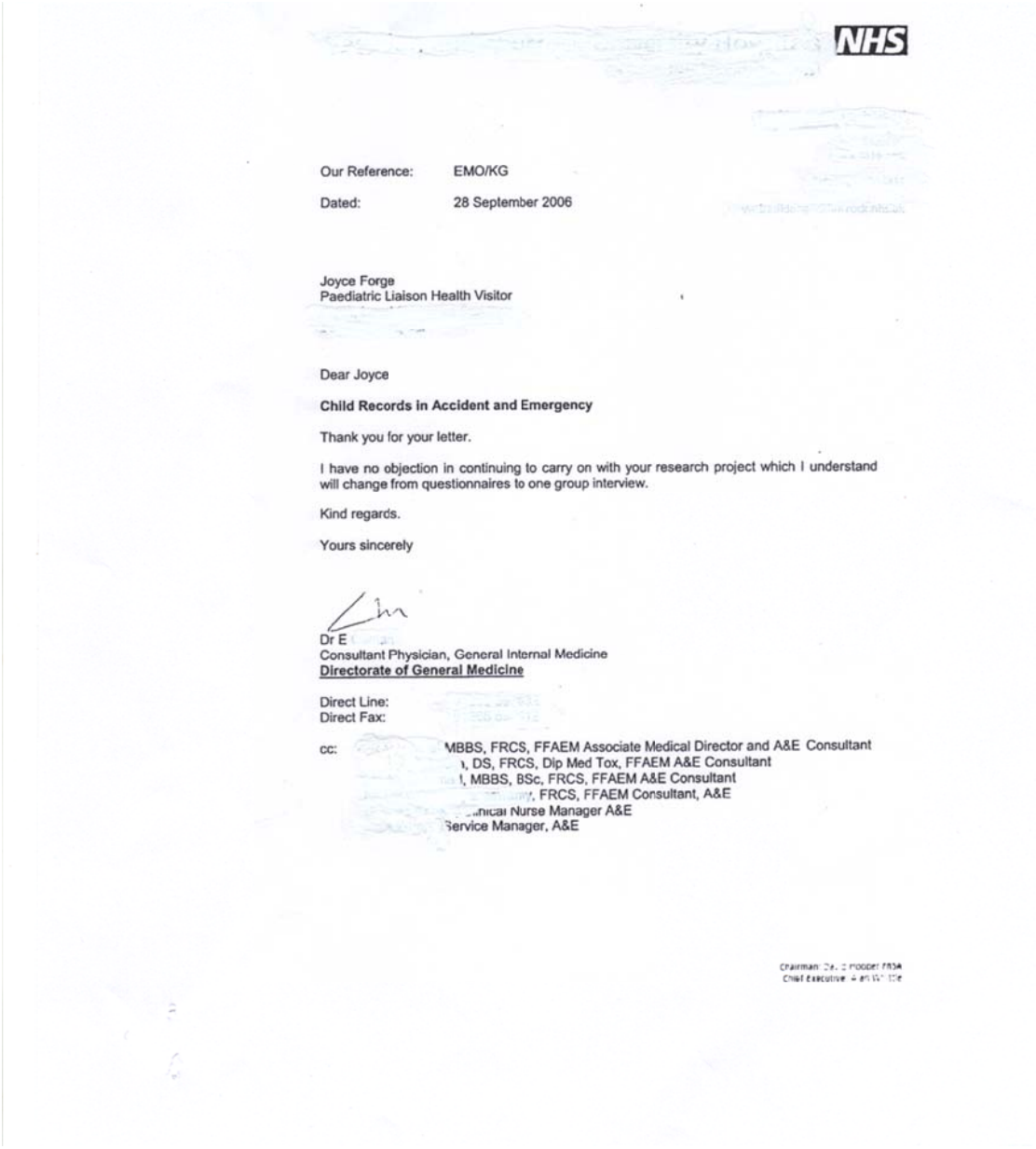
The participants will have the opportunity to explain in depth their collective views and perceptions on the sharing of children's (0-16 years) A&E records. In order to ensure modes of effective record keeping that can better serve children presenting to emergency services.

The outcome of the research study will also form part of my postgraduate studies in health and social care, which I am currently undertaking at Anglia Ruskin University.

Yours sincerely
Joyce Forge
Paediatric Liaison Health Visitor.

Cc. A&E Consultants, Senior Nurse-Modern Matron and Service Manager
Accident and Emergency Department

Appendix 17 Response from Sub-Director Emergency Care



NHS

Our Reference: EMO/KG

Dated: 28 September 2006

Joyce Forge
Paediatric Liaison Health Visitor

Dear Joyce

Child Records in Accident and Emergency

Thank you for your letter.

I have no objection in continuing to carry on with your research project which I understand will change from questionnaires to one group interview.

Kind regards.

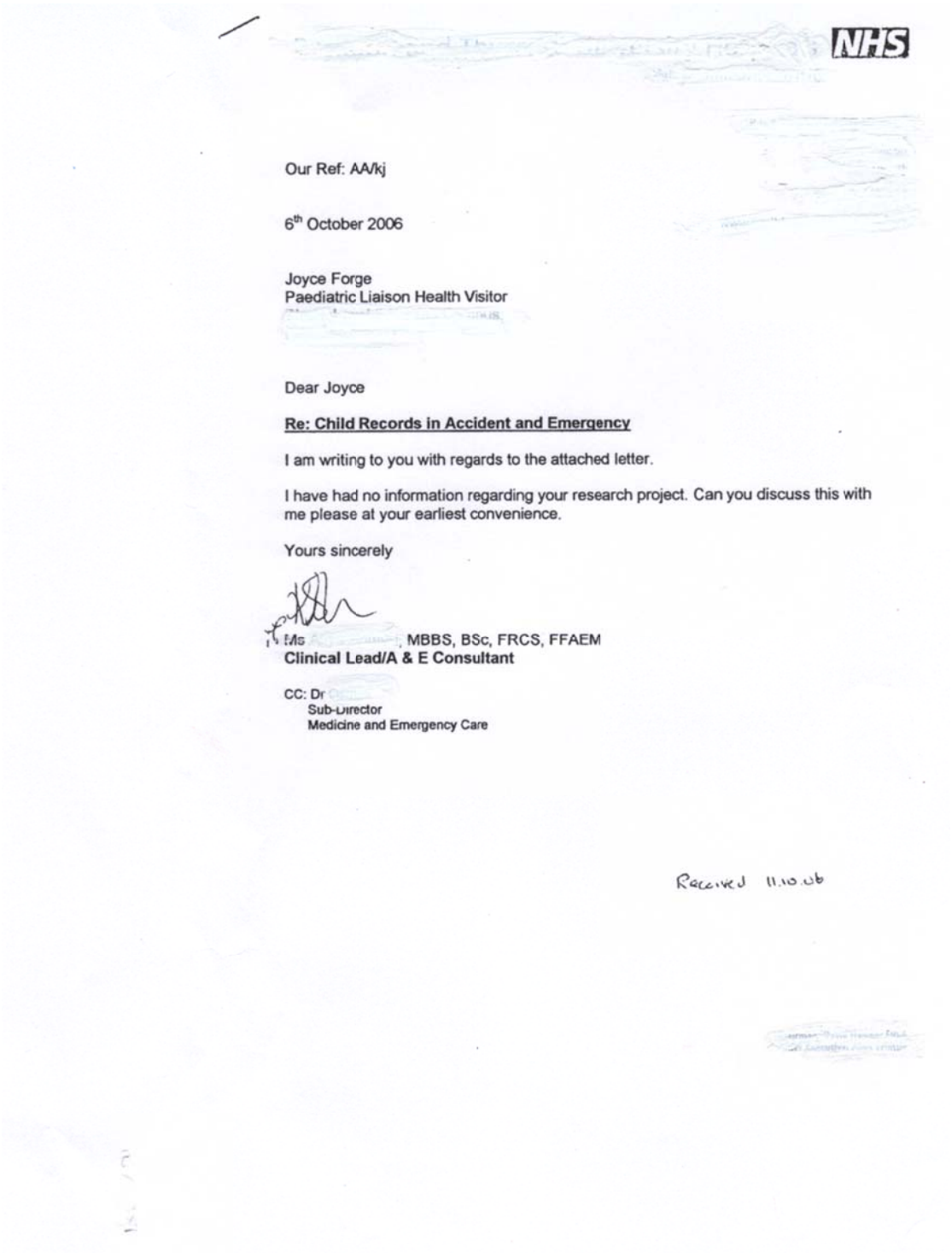
Yours sincerely

Dr E
Consultant Physician, General Internal Medicine
Directorate of General Medicine

Direct Line:
Direct Fax:

cc: MBBS, FRCS, FFAEM Associate Medical Director and A&E Consultant
, DS, FRCS, Dip Med Tox, FFAEM A&E Consultant
, MBBS, BSc, FRCS, FFAEM A&E Consultant
, FRCS, FFAEM Consultant, A&E
...nical Nurse Manager A&E
Service Manager, A&E

Appendix 18 Letter from Clinical Lead/A&E Consultant



NHS

Our Ref: AA/kj

6th October 2006

Joyce Forge
Paediatric Liaison Health Visitor

Dear Joyce

Re: Child Records in Accident and Emergency

I am writing to you with regards to the attached letter.

I have had no information regarding your research project. Can you discuss this with me please at your earliest convenience.

Yours sincerely

Ms , MBBS, BSc, FRCS, FFAEM
Clinical Lead/A & E Consultant

CC: Dr
Sub-Director
Medicine and Emergency Care

Received 11.10.06

Appendix 19 E-mail correspondence from A&E Managers

From:
Sent: 07 March 2008 12:07
To:
Cc:
Subject: Meeting Joyce Forge

Hi Sarah

Thanks for coming in to speak to me about this matter.

Basically I am asking you to meet Joyce Forge on an overtly scheduled basis, initially every 2/52 to discuss any issues that she may have in relation to safeguarding (children). Can you set meetings up with Joyce ASAP and explore the following issues:

- The number of lost paed cards
- The issues that these lost cards present to us
- The type of staff involved in any mismanagement of paediatric cases from a safeguarding perspective
- And any other issues that Joyce feels that we need to be made aware of

If you can feedback the issues to Julie and I ASAP that would be great

I have copied in Jo and Katy so that they are aware of the high priority that these issues continues to be in both Julies and my diary

Thanks for your help

Regards

Gerard

Jo

Pff joyce forbes

Ta

G

****

The information contained in this email may be subject to public disclosure under the Freedom of Information Act 2000. Unless the information is legally exempt from disclosure, the confidentiality of this email, and your reply, cannot be guaranteed. It is intended solely for the addressee. Please notify the sender immediately if you are not the intended recipient. Access to this email by anyone else is unauthorised. If you are not the intended recipient, any disclosure, copying, distribution or any action taken or omitted to be taken in reliance on it, is prohibited and may be unlawful.

****

Dear Sarah

Please can we meet on Wednesday 26th March at about 10am to discuss the recent audit about child protection issues, hope this is convenient for you?

Regards
Joyce Forge

Hi Joyce,

Have spoken with Gerard today re; your recent audit about child protection issues. I would like to arrange an initial meeting with you to discuss these concerns and to start an action plan to improve these. I then suggest that we meet on a regular basis, every 2 weeks to begin with, to ensure that we are following the action plan that we devise.

I understand you are on annual leave until March 17th. I am at work on the 20th, 21st,25th,26th and 28th(pm better as have meeting in morning)March. Hope one of these dates will be suitable for you to have the initial meeting.

Regards

Sarah

****
****

****
****

Dear all,

Following safeguarding meeting:
Find below the details that we are hoping to have printed on to a sticker to go in all A/E cards as an alert for all staff to think Safeguarding.These will eventually be permanently printed in all cards once the re design has been agreed. as these will not be available until next year, we needed something in the mean time.

We don't have a lot of space so need to keep the questions to a minimum, but important. I have shown them to Joyce, who is happy with the questions that i have drafted. If you can think of anything that is glaringly missing, or want to reword anything that is there then feel free to let me know.

Once i have had back any comments i will be in touch with the communications team about printing these on to labels. We anticipate that the receptionists will stick these in to the patients cards as they are printed.

DRAFT

1. Is the patient a frequent attender to A/E ? yes/no
If yes, note number of attendances.
2. Are you concerned about this number of attendances? yes/no
If yes, Discuss with patient/Parent reasons for attending A&E.
3. Do you have any safeguarding concerns? yes/no
If yes, who have you discussed these with.
Document all answers that need expanding in space below.

From:
Sent: 26 March 2008 11:05

To:
Cc:
Subject: FW: Meeting Joyce Forge

Hi Sarah/Joyce

Thanks for meeting this morning

We agreed the following

1 Clearly identify a single page of the multidisciplinary notes of the A&E card to be dedicated to addressing safeguarding issues. This will cover both adult and paed safeguarding issues. It will be the responsibility of the treating practitioner (Medical or Nursing) to complete this section during the consultation (not at Triage)

2 The safeguarding page will have information printed at source and will include questions such as:

Attendance frequency
Have you explored the attendance frequency
Has there been a delay ion attendance
Have you informed the patient/NOK that the details of attendance may be passed onto community colleagues
An action section that will clearly outline the action that may be necessary from a safeguarding perspective

3 We agreed that a small subgroup (max 5 people) would clarify the type of questions to be included.

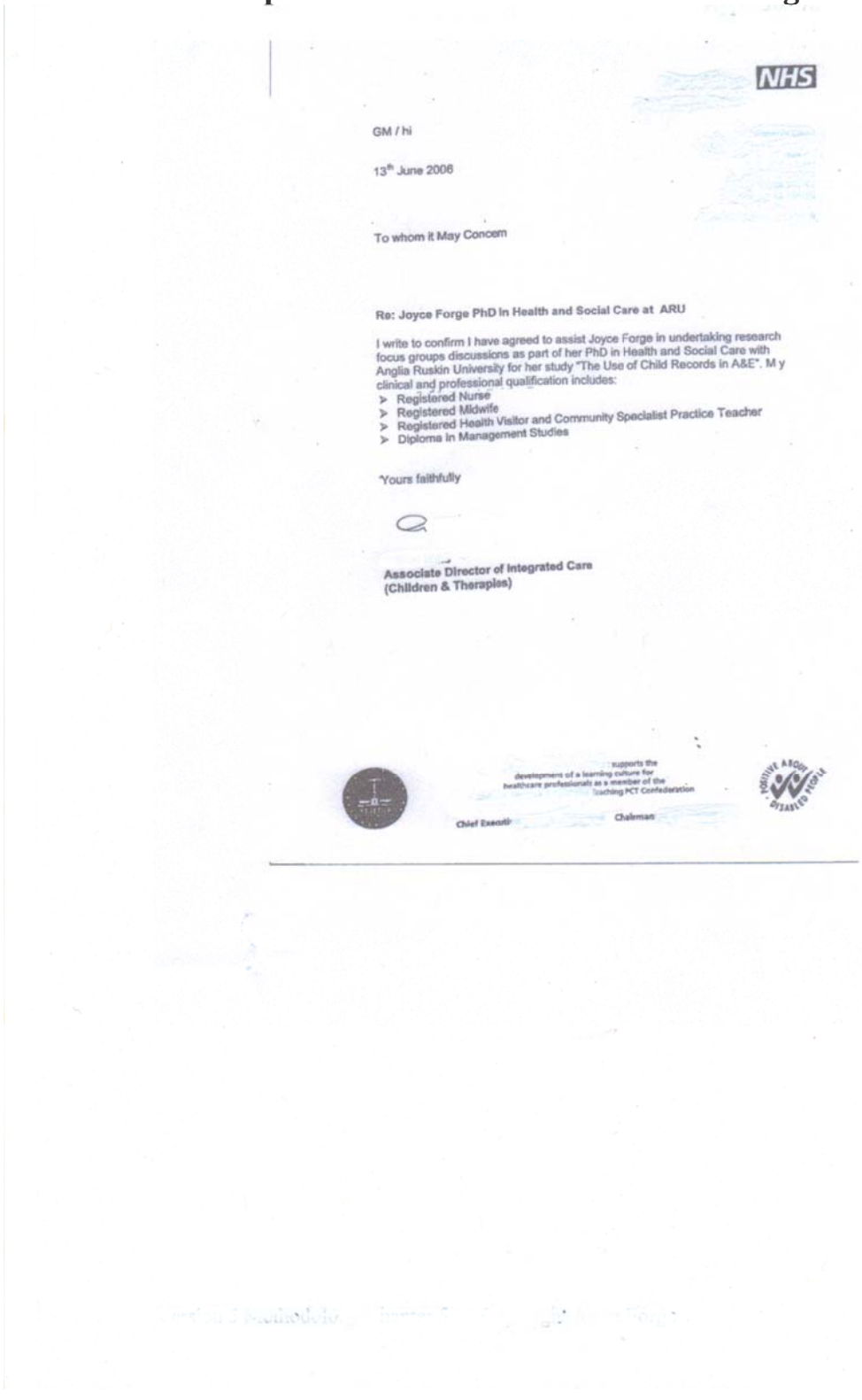
4 I made it clear to the group that the above points could not be implemented until 2009 as we have ordered our 2008 stock of cards and these have already been printed

Sarah
Can you lead on the set up of the subgroup and ensure that Joyce is involved in the exact design.

Steve
Joyce raised the matter of access to ethnic origin and other data (such as time of injury) that is recorded by the reception staff on booking in. I do not think that it is possible for this data to "fit" in the printed A&E card, but I do think you may be able to run a report that will capture this data to give to Joyce each day. Steve, can you let me know if this is possible please. The main data

sets are date and time of incident and ethnic origin, obviously related to A&E attendance number.

Thanks
Gerard



NHS

GM / hi

13th June 2006

To whom it May Concern

Re: Joyce Forge PhD In Health and Social Care at ARU

I write to confirm I have agreed to assist Joyce Forge in undertaking research focus groups discussions as part of her PhD in Health and Social Care with Anglia Ruskin University for her study "The Use of Child Records in A&E". M y clinical and professional qualification includes:

- Registered Nurse
- Registered Midwife
- Registered Health Visitor and Community Specialist Practice Teacher
- Diploma in Management Studies

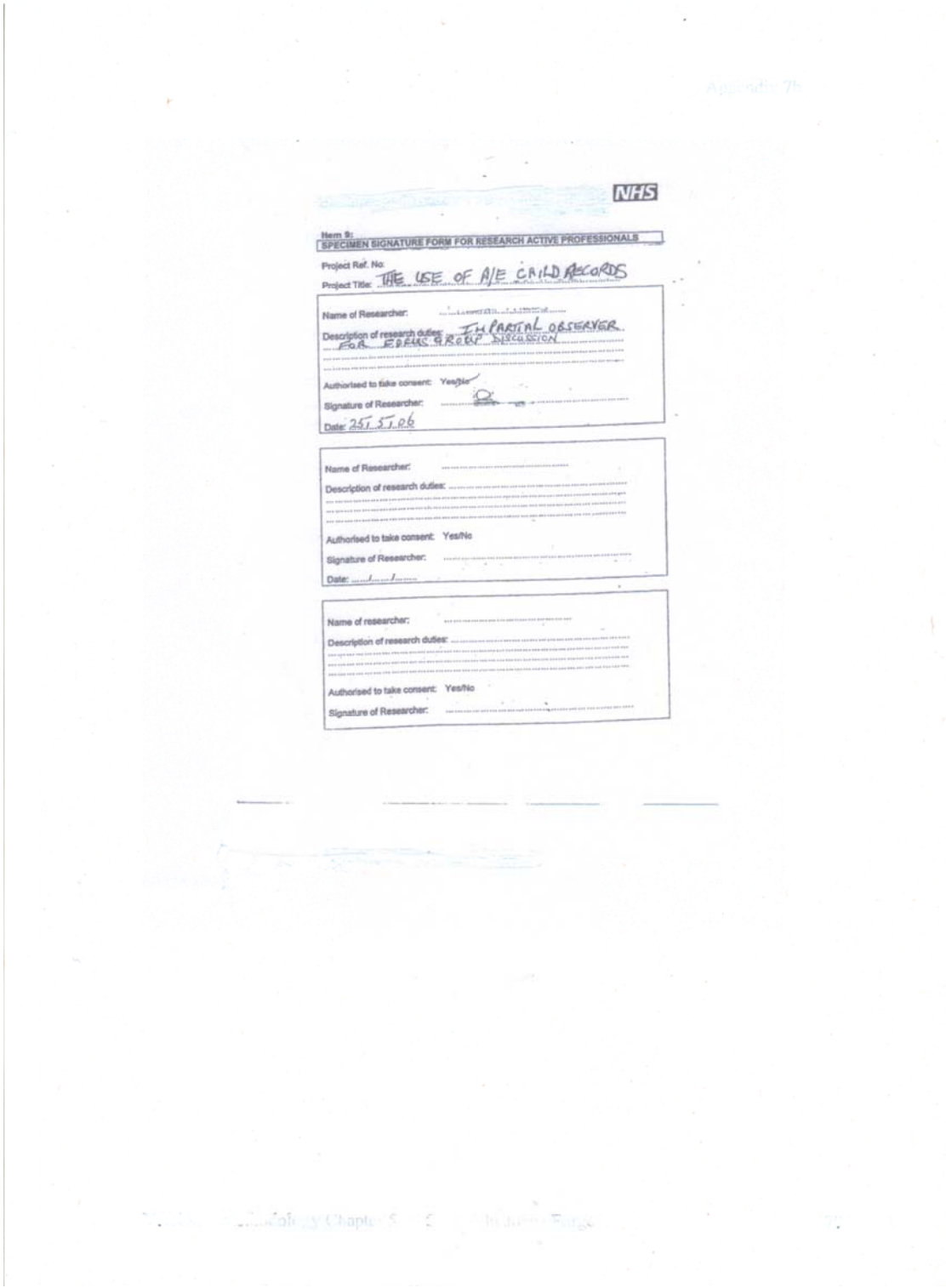
Yours faithfully

Associate Director of Integrated Care
(Children & Therapies)

supports the development of a learning culture for healthcare professionals as a member of the Teaching PCT Confederation

Chief Executive

Chairman



NHS

Item 9:
SPECIMEN SIGNATURE FORM FOR RESEARCH ACTIVE PROFESSIONALS

Project Ref. No:

Project Title: THE USE OF A/E CHILD RECORDS

Name of Researcher: [redacted]

Description of research duties: IMPARTIAL OBSERVER FOR FOCUS GROUP DISCUSSION

Authorised to take consent: Yes/No

Signature of Researcher: [redacted]

Date: 25.5.06

Name of Researcher: .....

Description of research duties: .....

Authorised to take consent: Yes/No

Signature of Researcher: .....

Date: ...../...../.....

Name of researcher: .....

Description of research duties: .....

Authorised to take consent: Yes/No

Signature of Researcher: .....

APPENDIX 21 Illustration of local A&E child records

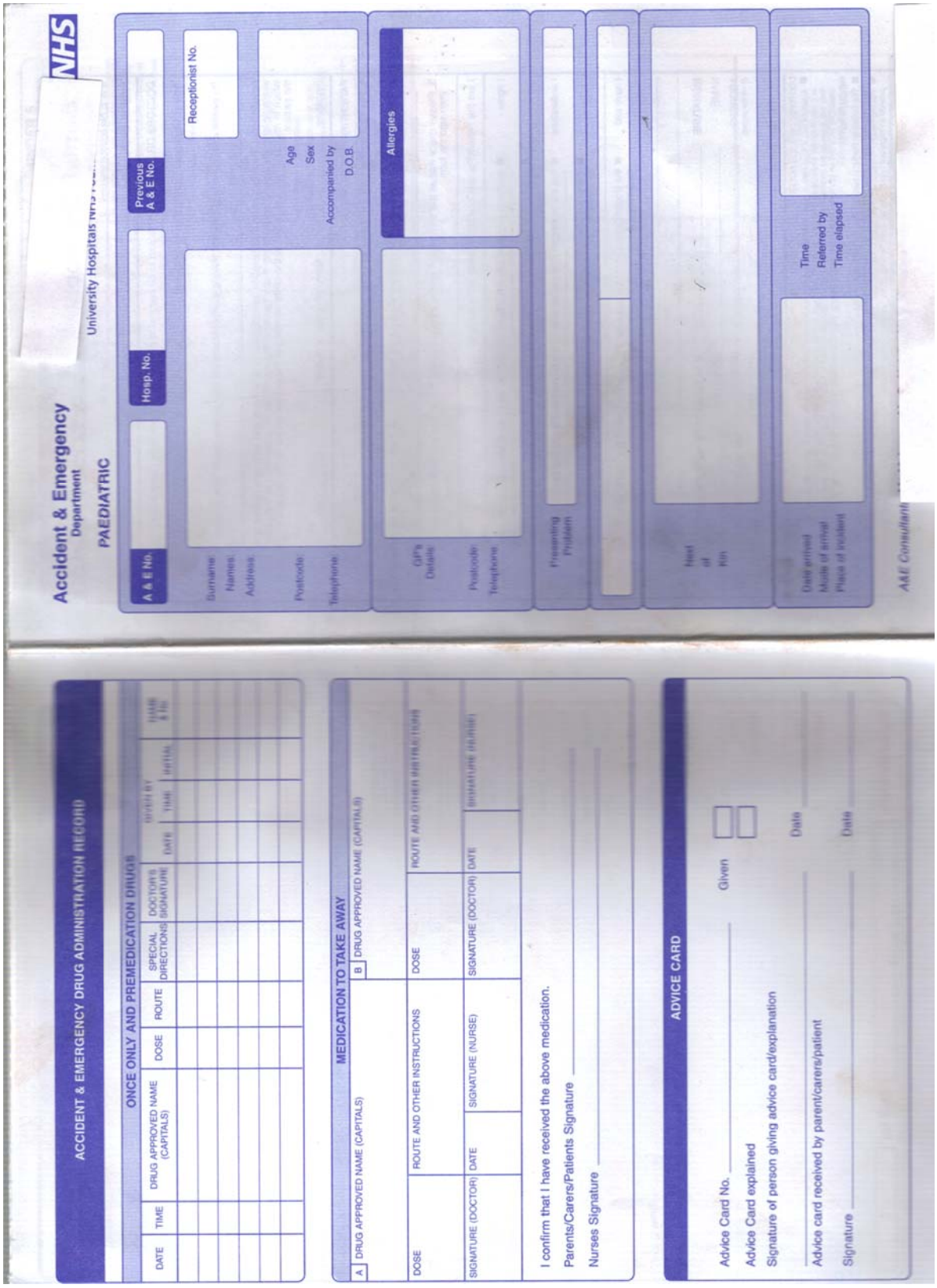


Illustration of child records used locally (this is the full size when opened; it is normally folded in two when in use).

APPENDIX 22 Outline of local A&E child records

Page 1	Demographics such as name, address, and age are recorded
Page 2	The written content on page 2 is considerable, contains a heading and a consent form for medical or dental investigations, treatment or operations
Page 3	Contains a heading coma scale over 5-under 5, this is a densely printed page in small font sizes and a variety of lines, and dots.
Page 4	Consists of a body map
Page 5	The first part of page 5 shows the map of a head, hands and feet and below this an admission checklist of patient valuables and a discharge checklist of two lines.
Page 6	For recording multidisciplinary notes in free hand.
Page 7	For recording multidisciplinary notes in free hand.
Page8	For recording multidisciplinary notes in free hand.
Page 9	The top part is for recording results such as x- rays and any other treatment given whilst the rest of that page which amounts to just over half a page, covers critical factors concerning the safeguarding of children
Page 10	For the recording of medication

APPENDIX 23 Relevant parts of the Trust record keeping policy for the study

Health Records Policy

Contents

NHS

Document Title:	Health Records Policy
Document Purpose:	The Health Records Policy has been produced to provide clear guidance of the procedures that must be followed in relation to all aspects of Health Records Management including the creation, maintenance, storage, retention and destruction of the Health Records together with guidance on how to ensure availability. The content of this policy has been developed in line with NHS guidance, relevant legislation and organisational procedures and aims to communicate the importance of ensuring that high standards of Health Records management is maintained within the Trust.
Document Statement:	
Document Application:	Organisation wide
Responsible for Implementation:	Health record service manager, Health Records Committee, General managers, all staff

Main imperatives of this Document are:
The Trust is committed to maintaining Health Records and in particular aims to ensure that the following are adhered to at all times:

- The Trust will comply with all legislation, guidance and standards relating to Health Records Management
- The Trust will take all reasonable organisational and technical measures to ensure that the health records it holds will be kept secure and used only for fair and lawful purposes
- The Trust will ensure that the transfer and sharing of health records is strictly controlled
- The Trust will ensure that health records availability is monitored for outpatient appointments and where necessary action is taken to maximise availability of records.

The Trust will ensure that provisions are in place to preserve certain records that need to be held for longer than the national minimum retention period

Document Classification:	Information Management	Document Reference:	IM/PO/00002
Version Number:	2.0	Secondary Reference:	
Issued by:	Director of Planning and Service Development	Effective Date:	December 2004
Author:	Health records Service Manager	Review Date:	January 2007
Sponsor:	Director of Planning and Service Development	Expiry Date:	December 2014

Associated Documents

1.

APPROVAL RECORD

Validated by Facilitator:	Clinical Safety Manager	Date: March 2007
Agreed by Specialist Group:		Date:
Agreed by Board Sub-Committee:		Date:
Approved by Board Committee:	Board Directors	Date: December 2004
Approved:		Date:

7. USING THE HEALTH RECORD

7.1 Making Clinical Entries

This section should be read in conjunction with the Trust **Policy for the Identification, Maintenance and Transfer of Clinical Records,** which provides detailed guidance for Health Professionals in the use of Health Records. When making clinical entries into the Health Records the following points must be observed:

- All entries will be written legibly and be readable on any photocopies.
- All entries will be clear, factual, unemotional, unambiguous and objective. The record will not include jargon meaningless phrases, irrelevant speculation and offensive subjective statements.
- All entries will be made recording facts and observations written at the time of, or soon after, the events described, providing current information on the care and condition of the patient and will be in chronological order.
- Any factors that may jeopardise standards or place the patient at risk must be identified in the Health Record. The individual practitioner identifying that risk is then responsible for documenting the action or planned action taken to minimise the risk.
- The need for referral to specialist practitioners with necessary knowledge and skills to meet needs must be documented. A note of the date and time of referral will be made.
- Evidence of patient/family/carers involvement in care will be documented at every opportunity. Communication between health care professionals, the patient, family and carers is to be documented.
- In line with national and legal guidance clinical records should be written (wherever possible) in terms, which the patient will be able to understand.
- It is essential that those who make, access and use clinical records understand the ethical concepts of professional practice which relate to them e.g. the need to protect confidentiality, to assist patients to make informed decisions, to ensure informed consent
- The person making the entry will ensure that the entry made is totally accurate and based on respect for truth and integrity.
- On NO account will clinical records be used to air differences of opinion between health care professionals.
- It is essential that observations or action to be taken is documented when vital signs or tests are abnormal. Review times and dates will be documented. It is essential that reasons are explained if actions are taken in the patient's best interests.
- Do not skip lines or leave blank spaces or squeeze extra words onto a line
- A line should be drawn through any empty space at the end of an entry

7.2 Errors in documentation

If an error is made in the Health Record the person responsible must draw a line through the incorrect entry. The word "error" must be written above or near the incorrect entry. The individual must initial, print name, date and record the time the error was corrected. The individual will make the correct entry and if necessary use a supplementary page or make a late entry on the next available line. On NO occasion is correction fluid (Tippex) to be used in the compilation of records. On NO occasion are the records documented by others to be changed.

7.3 Retrospective Entries

Retrospective entries should only be made in unusual or extenuating circumstances. Such entries should only be made before the end of the shift or day in question. It must be made clear that the entry is retrospective and the reason for the late entry recorded.

APPENDIX 24 Personal correspondences

From: Forge Joyce PCT [mailto:Joyce.Forge@
Sent: 14 April 2008 14:23
To: JB@sectae.org.uk
Subject: Children A&E

Dear Dr. Benger

My name is Joyce Forge. I am a paediatric liaison health visitor at PCT. The objective my role is to facilitate information exchange, and to ensure continuity of care, with special reference to child protection, child development and supporting parents

I am conducting a research study which seeks basic data about the knowledge and use of children's (0-16 years) A&E records. This research is the basis of my doctoral study in health and social care and has been ethically approved in 2007.

I have read your article (Quality improvement report) in the 2002 BMJ which I have found to be very informative. I wondered if there is an update/ you are conducting any further studies in the same area and if there is any information you would be willing to share with me.

Thank you in advance for support or information you are willing to share.

Your sincerely

Joyce Forge

Specialist Health Visitor Paediatric Liaison

This e-mail is confidential and privileged. If you are not the intended recipient please accept our apologies; please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents: to do so is strictly prohibited and may be unlawful. Please inform us that this message has gone astray before deleting it. Thank you for your co-operation.

From: JB [mailto:JB@sectae.org.uk]
Sent: 14 April 2008 22:29
To: Forge Joyce PCT
Subject: RE: Children A&E

Dear Joyce,

Thanks for your message. I am no longer conducting research in this area, so have no further information to offer.

I wish you every success with your study.

Best regards,

Jonathan.

Forwarded Message: Records Emergency Departments

Records Emergency Departments

Monday, 14 April, 2008 12:15 PM
From: "Forge Joyce PCT<Joyce.Forge@Pct.nhs>
To:jtaitz@doh.health.nsw.gov.au

Dear Doctor Taitz

My name is Joyce Forge. I am a paediatric liaison health visitor at, Primary Care Trust, United Kingdom. The objective of my role is to facilitate information exchange, and to ensure continuity of care, with special reference to child protection, child development and supporting parents

I am conducting a research study which seeks basic data about the knowledge and use of children's (0-16 years) A&E records. This research is the basis of my doctoral study in health and social care and has been ethically approved in 2007.

I have read your article (long bone fractures in children under 3 years of age) in the paediatric, child health journal 40(2004) which I have found to be very informative. I wondered if there is an update/ you are conducting any further studies in the same area and if there is any information you would be willing to share with me.

Thank you in advance for support or information you are willing to share.

Your sincerely

Joyce Forge

Specialist Health Visitor Paediatric Liaison

-----Original Message-----
From: imsshost@doh.health.nsw.gov.au
[mailto:imsshost@doh.health.nsw.gov.au]
Sent: 14 April 2008 12:16
To: Forge Joyce PCT
Subject: Mail could not be delivered

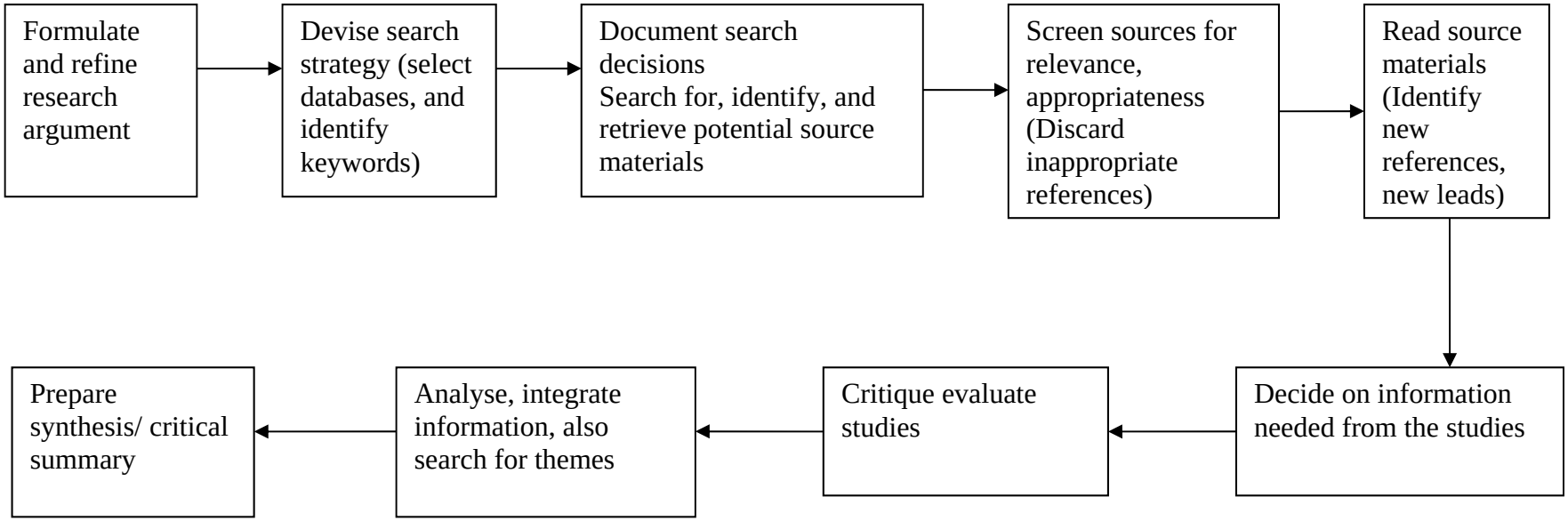
IMSS System Level Notification

Sent <<< RCPT TO:<jtaitz@doh.health.nsw.gov.au>
Received >>> 550 no such recipient

Unable to deliver message to
<jtaitz@doh.health.nsw.gov.au> (and other
recipients in the same domain).

This email was sent in response to a filtering outcome
or IMSS program
function issue

APPENDIX 25 Flow chart for literature review tasks



Flow Chart of literature review tasks. (Source: Polit & Beck, 2010)

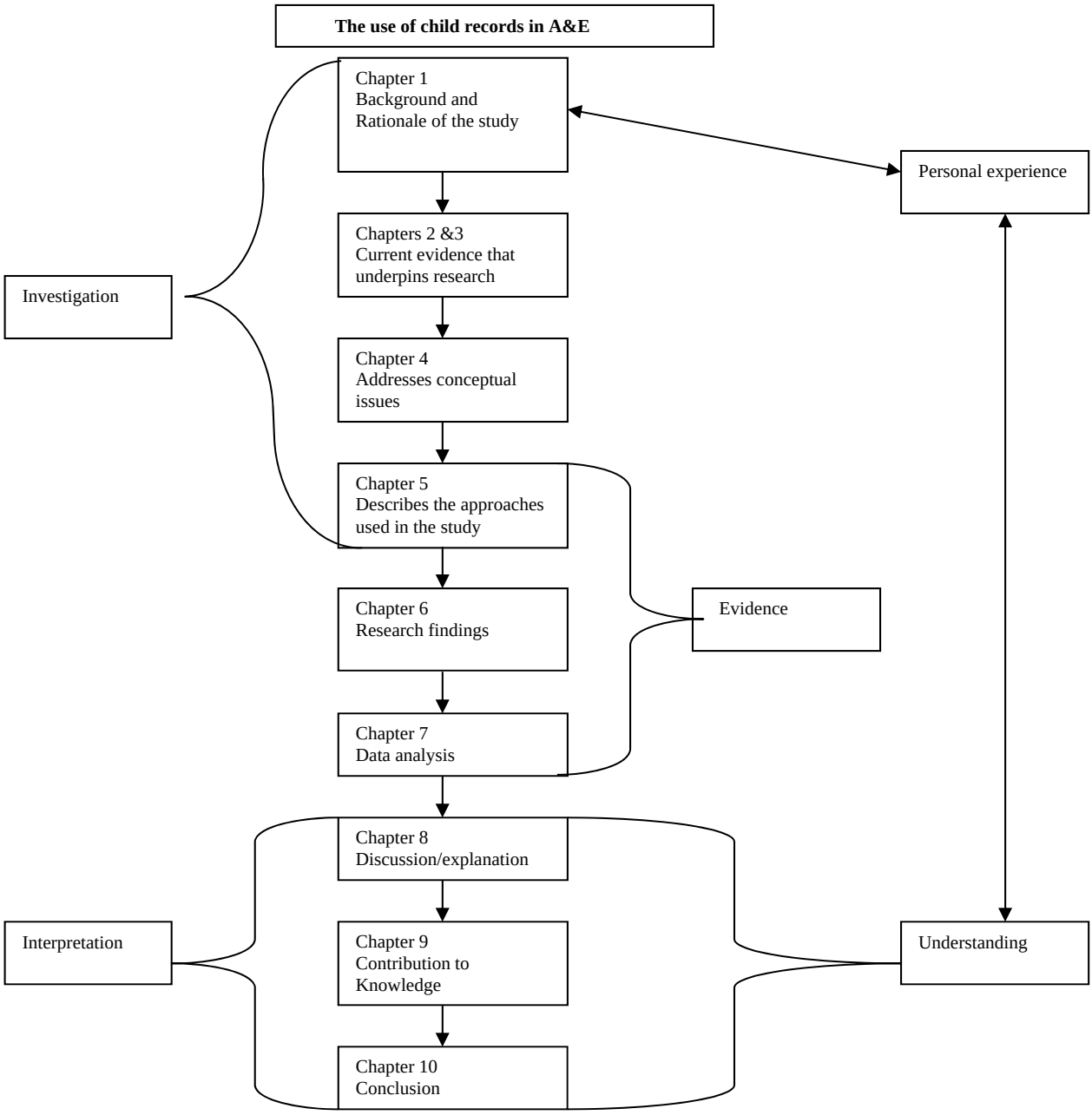
APPENDIX 26 Process for the search for papers relevant to the study directly relating to the use of A&E child records

Databases	**Key Words**	Hits	Relevant work to topic identified and met criteria	Date
Applied Social Sciences Index and abstracts (ASSIA)	Safeguarding children and information sharing	4	None	24-08-09
	Information sharing and child records	6	None	24-08-09
	Child records and A&E	9	Three	24-08-09
Medical Literature On-Line MEDLINE via SCIRUS/BioMedNet	Safeguarding children and information sharing	1	None	24-08-09
	Information sharing and child records	8	One	24-08-09
	Child records and A&E	32	none	24-08-09
Cumulative Index to Nursing and Allied Health Literature (CINAHL)	Safeguarding children and information sharing	5	None	25-08-09
	Information sharing and child records	10	One	25-08-09

	Child records and A&E	31	Three	25-08-09
Social Sciences Citation Index (ISI Web of Science)	Safeguarding children and information sharing	0	None	25-08-09
	Information sharing and child records	2	None	25-08-09
	Child records and A&E	18	Two	25-08-09
Child data	Safeguarding children and information sharing	0	None	25-08-09
	Information sharing and child records	0	None	25-08-09
	Child records and A&E	0	None	25-08-09
British Nursing Index	Safeguarding children and information sharing	5	Two	26-4-09
	Information sharing and child records	1	None	26-08-09
	Child records and A&E	1	None	26-08-09
Cochrane Reviews	Safeguarding children and information sharing	1	None	26-08-09
	Information sharing and child records	19	None	26-08-09
	Child records and A&E	2	None	26-08-09

Dissertation Abstracts on line	Safeguarding children and information sharing	0	None	30-08-09
	Information sharing and child records	0	None	30-08-09
	Child records and A&E	0	None	30-08-09
Conference Papers Index	Safeguarding children and information sharing	0	None	26-08-09
	Information sharing and child records	0	None	26-08-09
	Child records and A&E	0	None	26-08-09

APPENDIX 27 Flow chart of how chapters of thesis are linked



APPENDIX 28 Summary illustration of data collection methods for the use of child (nought -16 years) records in A&E.

The Study	Type	Aims	Sample	Type of data			Time- scale			Analysis	
				Stage 1	Stage 2	Stage 3	Stage 1	Stage 2	Stage 3	Hermeneutic phenomenological Colaizzi's (1978) approach	
The Use of Child Records in A&E	A Qualitative Case Study	To understand the social construction that people have regarding record keeping. To elicit A&E staff and other agencies (colleagues from health and social care environments, nurses, doctors, health visitors, social care) perceptions of the use child records in one A&E department (in one location).	Child records 378 (15%) Group discussion A&E staff (12) Group discussion local child protection group (12)	Analysis of child records	Focus group (1)	Focus group (1)	One 24-hour day a month on a different day of each week for six consecutive months (26 weeks)	Group discussion July 2007 (1)	Group discussion August 2007 (1)	Stage 1 Supported by Auto-data computer soft ware, PCT audit department	Stage 2 & 3 Supported by NVivo computer soft ware

Source: Qualitative data analysis for applied policy research. In analysing Qualitative data. Jane Ritchie and Liz Spencer (ed. Alan Bryman and Robert Burgess, 1994)

APPENDIX 29 Chronological history of high profile child protection cases in England (List is not exhaustive)

Event	Inquiry	Year	Legislation/Political action
Dennis O'Neill a young boy who died as a result of the treatment he received from his foster parents	Curtis Committee	1946	First formal public enquiry
Maria Colwell, a 7-year-old beaten to death by her stepfather in Brighton	DHSS	1974	Triggered a national debate over the care of children, this led to the establishment of the modern child protection system
Jasmine Beckford neglect and abuse, lead to the death of this 4-year-old and occurred whilst she was in the statutory care of the Local Authority	Blom-Cooper	1985	The inquiry panel made a number of recommendations the tightening of monitoring procedures, the improvement of inter-agency collaboration, and the need for more specialised training. The Children Act 1989
The management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995	Kennedy	2001	Made recommendations to help to secure high quality care for children across the NHS
Victoria Climbie an 8-year-old, who died in 2000 as a result of months of awful ill-treatment at the hands of two individuals who were supposed to be caring for her	Laming	2003	The Children Act 2004, Every Child Matters 2004a; Laming pledged that her death would mark an "enduring turning point in ensuring the proper protection of children in this country".
Jessica Chapman and Holly Wells murdered by Ian Huntley a school caretaker	Bichard	2004	The National Service Framework for Children 2006, and Working Together to Safeguard Children, 2006.
Peter Connelly (Baby P) a 17-month-old child tortured and killed by his mother and her boyfriend.	Laming	2009	The Protection of Children in England: A Progress report.

Appendix 30 Topics covered and the changes made by each research

Researchers	Topic covered	Changes made
Gilbert et al 2009	Recognising and responding to child maltreatment.	The production of guidelines based on systematic review of research evidence
Luderer & Behrens 2008	Inter-professional documentation both medical and nursing.	Recommended that inter professional documentation be applied in all cases
Carter et al, 2007	Nursing documentation in an accident and emergency department	In service education on documentation was initiated
Mc Fetridge et al 2007	Transfer of information between nurses from emergency departments and critical care units	Suggests a structured framework or aide memoir to guide the hand over process and collaborative work between nursing teams
Forge 2006	Improving services for children: sharing accident and emergency records	Poster, attributed to best practice guidelines and improvement of multi-professional team understanding and team work
Law et al, 2006	Adequacy of trauma documentation in accident and emergency records	Preformatted charts were suggested to increase the rate of documentation
Saunders et al 2005	Identifying non-accidental injury in children presenting to A&E departments	Suggests quality information will help to identify children at risk.
Taitz et al 2004	Long bone fractures in children under 3 years of age	Instituted a series of education sessions and developed special referral guidelines
Atwal & Caldwell 2002	Integrated Care Pathways to improve inter-professional collaboration integrated documentation.	Implementation of integrated care pathway
Benjer & McCabe 2001	Documentation of pre-school children attending A&E.	Developed simple and easy to use check list.
Chan et al 2000	International comparison of childhood injuries	Suggests that improvement could be made if the code for the external causes of injury

		and the abbreviated injury scale were made mandatory.
Green et al 1998	Quality of documentation in psychosocial history taking.	Argued for changes in medical education
Christopher et al 1995	Extent to which documentation of medical records is completed for dependent children who present for evaluation of an acute injury	Suggests establishment of educational programmes

APPENDIX 31 Chart of NHS history

1948	NHS came into effect
1948-1957	Everyone eligible for care
1958-1967	Treatment was improving. Better drugs introduced
1968-1977	NHS 1974 re-organisation. Clinical and organisational optimism
1978	Acknowledgement that financial bounds existed
1982	NHS restructure to simplify the organisation
1983-1985	General management introduced
1988	Introduction of the internal market
1990	NHS reforms. Community Care Act
1991-1995	All providers became independent NHS Trusts
1998	Varying initiatives, alterations in policy, financial and organisational changes
2000	Internal market abolished. The NHS Plan brings about the biggest change since the NHS was formed in 1948
2002	Launch of Primary Care Trusts
2004	First Foundation Trust created
2006	Extended patient choice
2007	Extended patient choice network is launched
2008	Free choice is introduced
2009	Change for life for people introduced
2010-2011	NHS reform in progress

Source: Rivett (2009)

APPENDIX 32 Government documents influencing current child protection system in England.

1989	The Children Act - key legislation concerned with the welfare of children (DH, 1989).
2002	Joint Chief Inspectors' report on arrangements to safeguard children (DH, 2002a).
2003	Laming report - independent statutory inquiry into the circumstances leading to the death of Victoria Climbie (Laming, 2003).
2003	The Green Paper Every Child Matters (DfES, 2003b).
2004	The Children Act – provides the legal framework for the Every Child Matters programme (DH, 2004).
2004a	Every Child Matters document- sets out a framework for improving services for all children (DfES, 2004a).
2006	Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2006)
2009	The Protection of Children in England: A Progress Report – provided details of the progress being made across the country following a previous report in 2003 (Laming, 2009).
2010	Working Together to Safeguard Children – revised version updated to reflect changes to policy (HM Government, 2010).
2011	Review of Child Protection in England- Part of a national drive to improve the quality of child protection services (Munro, 2011).

APPENDIX 33 Recent documents to promote increasing inter-agency collaboration

2003	The statutory guidance to support Multi-agency Public Protection Arrangements (MAPPA), formed the basis of public protection, including the protection of children, and operates on a multi-agency partnership basis throughout England and Wales (NPS, 2003)
2004	The Children's Trust Framework underpinned by the Children Act 2004 (DH, 2004)
2004	The information Sharing and Assessment programme (DfES, 2004)
2004	The Team Around the Child, a model of service provision in which a range of different practitioners come together to help and support an individual child led by the voluntary sector (DfES, 2004a)
2004	The National Service Framework (NSF) for Children Young People and Maternity Services (DH &DfES, 2004b)
2005	The Common Core Skills and Knowledge for the Children's Workforce (for everyone working with children, young people and families (DfES, 2005)
2005	The Early Support Programme a central government mechanism for achieving better family focused services (DfES, 2005)
2006	The role of Lead (LP) Professional to coordinate action if more than one services were involved (DfES, 2006)
2007	The Children's Plan - a ten year strategy to make England the best place in the world for children to grow up (DCSF, 2007)
2007	Staying Safe - the first ever cross Government strategy on improving children and young people's safety (DCFS, 2007)
2008	The information Sharing Index (Contact Point), was rolled out across local authorities in 2008, in order to help practitioners contact each other more easily and quickly to support early intervention and to prevent children from falling through the net (DfES, 2006)

APPENDIX 34 Various theoretical definitions of nursing theorists

Nursing theorists	*Year*	*Theoretical definitions*
Henderson	*1966*	*Conceptualises the nurses' role as assisting sick or healthy individuals by meeting 14 fundamental needs which include communicating with others.*
Orem	*1971*	*Includes three related concepts: self-care, self-care deficits and nursing systems.*
Watson	*1979*	*Believes the practice of caring is central to nursing, it is the unifying focus for practice.*
Roper, Logan & Tierney	*1980*	*The basis of this model was developed from the theories of the psychologist Maslow (1954) and his hierarchy of biological need.*
Kings	*1981*	*Demonstrates the relationship of interacting systems. Operational systems (individuals) interpersonal systems (groups such as nurse patients) social system (healthcare system).*
Leininger	*1991*	*This model emphasizes that health and care are influenced by elements of the social structure, such as technology, religious and philosophical factors, kinship and social systems, cultural values, political and legal factors, economic factors and educational factors.*
Parse	*1995*	*Sees the nurses' role as helping individuals and families to choose the possibilities, for changing the health process.*
Roy	*1997*	*This work focuses on the increasing complexities of person and environment self-organisation and on the relationship between and among people.*
Neuman & Fawcett	*2002*	*Views the patient as an open system consisting of a central core or basic structure (physiological, psychological, sociocultural, developmental and spiritual).*

APPENDIX 35 Professional peer reviewed journal publication

Safeguarding children by means of information sharing

Joyce Forge MSc, BSc, RN, RM, HV, FPCert
Specialist health visitor paediatric liaison,
South West Essex Community Services
and part-time PhD student, Anglia Ruskin University

Abstract

This study explored the purpose and use of children's (aged nought to 16 years) records in an emergency department (ED) as a means of safeguarding children. It aimed to elicit ED staff and local child protection group perceptions of the use of these records.

A case study methodology was utilised to uncover the story of why and how ED child records were used. The study was carried out in three stages – an analysis of a purposive sample of ED children's records, a focus group with 12 ED staff members in the case study site, and a focus group with 12 members of the local operational child protection group.

The emerging findings indicate that child records are a good tool for communication, however the risk factors are not always recognised and the records are not sufficiently child focused. They also highlight that existing written records did not provide a format that enabled staff to record information comprehensively.

Key words

Information sharing, record keeping, safeguarding children

Community Practitioner, 2010; 83(1): 16-9.

Introduction

The improvement of information-sharing practice is a cornerstone of the government *Every child matters* strategy to improve outcomes for children.[1] Lord Laming's inquiry into the care of Victoria Climbié[2] revealed themes – identified by past inquiries – that resulted in a failure to intervene early enough. Failure to share information was one of the recurring themes to be identified.

This study draws on and contributes to the development of knowledge about the role of emergency department (ED) child records in relation to information sharing in the field of child protection, by seeking knowledge of how ED child records are used by health and social care professionals.

Study background

In 2001, a critical incident occurred locally concerning the availability of a child's ED records. Local evaluation of a previous study[3] prompted fundamental questions about the functions of the sharing of ED records (see Figure 1), which in turn led to the study reported in this paper.

The ethos behind the sharing of ED records was that it would encourage partnership between different professionals and improve communication, leading to enhanced continuity of care. This ethos is echoed in Standard 5 of the *National Service Framework for children, young people and maternity services*[4] (NSF) and *Working together to safeguard children*.[5] These national guidelines state that the welfare of children must always be regarded as of primary importance, as their age and potential vulnerability renders them powerless to protect their own interests. Moreover, the Laming reports[2,6] argue that those children with the greatest need are a particular issue for EDs.

The author is employed by primary care trust (PCT) community services as a paediatric liaison health visitor (PLHV), and located on the premises of the main district general hospital. This educational research study was conducted as part-fulfilment of a PhD thesis.

Aim of the study

The aim of this study was to elicit the perceptions of the use of ED child records from the diverse staff who shared the information that these records contain – nurses, doctors, health visitors and social care.

Methods

This research study used qualitative methods, since it sought basic data about knowledge of the purpose and use of children's (aged nought to 16 years) ED records (the needs of 17- to 18-year-olds were cared for by staff from the ED). This study used a case study methodology[7] in order to acquire a better understanding of how ED child records were used. This research did not attempt to generalise beyond the case study site. The study involved three stages – an audit of child records and two focus groups with local health and social care professionals.

Audit of child records

A purposive sample of ED child records was selected for audit. The average number of children between the ages of nought to 16 years visiting the ED per day was 63. For one 24-hour period a month on different days of each week for six consecutive months (26 weeks) a total of 378 (14.3%%) out of a possible 2646 of the records were analysed. If the number of records on the day of auditing was more than 63, the first 63 were analysed. If fewer than 63, the first records taken out of the drawer for the following 24 hour period made up the number to 63 for analysis. There was no intention to represent this as a statistically valid sample. This provided the basis for finding out:

- How records were being used
- What readers did with the information
- What was in child records, for example recording of issues that were causing concerns about these children.

The audit was conducted between 1 May and 5 November 2007. Using a researcher's checklist for data collection, standard 5 of the NSF[4] and the trust's record-keeping policy provided criteria for analysing the records.

There were two categories of records:

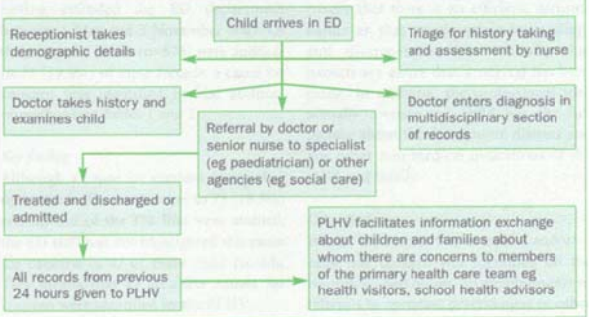
- Those indicating no cause for concern beyond the medical needs of the child
- Those indicating cause for concern and a need for action.

This second group were analysed in detail after being divided into two groups:

- Those concerns that were identified by members of staff in the ED
- Those concerns that were picked up by the PLHV alone.

The term 'cause for concern' refers to the records of any child who attended the ED and who needed support from services such as health visitors, school health advisors and social care.

Figure 1. Emergency department child records



Focus groups

Two focus groups were conducted – one with non-ED staff who were members of the local operational child protection (LOCP) group and one with ED staff. Both were facilitated by the researcher. Although the researcher's presence in the ED was only a small part of her working day and there was little familiarity between the researcher and the ED staff, it was recognised that this could be perceived as a conflict of interest. An impartial observer who took notes was therefore present during both focus group discussions.

Prompts for the focus group discussions (see Box 1) provided a strategy for addressing the research question, as well as generating rich and diverse views, opinions and experiences from the perspective of the staff who use the ED child records. By using this, while discussing and interacting with each other, participants were encouraged to concentrate on one another rather than on the facilitator. The wide range of participants involved in the focus groups differed in the nature and extent of their involvement and use of ED child records.

Non-ED staff

A purposive sample of 12 participant representatives from outside agencies (named safeguarding nurses and doctors, health visitors, school health advisors, community children's nursing, social care, GPs) was drawn from 30 members of the LOCP group, since they were recipients of part of the ED records. The LOCP group discussion took place in July 2007. This group was used to obtain information about opinions and perceptions of child records in the ED, their content and use, and participants were asked how and why they used child ED records. The focus group for the LOCP members was arranged following negotiation through the chairperson to take place during a working day, date and time convenient to members. The group discussion lasted 55 minutes, was audiotape-recorded and the information was transcribed later on.

ED staff

A purposive sample of 12 ED staff (nurses, doctors, clerical, healthcare assistants and managers) from the case study site was selected randomly from 120 members on the ED staff rota. The ED focus group discussion took place in August 2007. In order to gain insight into the collective perceptions and opinions of how and why child records were used in the ED, these staff were asked the same question as the non-ED staff. For practical reasons, the focus group was arranged following negotiation with the ED managers for early morning, taking shift patterns into consideration. The group discussion lasted exactly one hour, was audiotape-recorded and later transcribed.

Ethical issues

Ethical approval for the study was given in 2007. The nature of the research and the methods adopted required approval from the local research ethics committee and from the relevant research and development departments. The rationale of the research, methods adopted and intended outcomes were explained to all of the participants and organisations collaborating in the work.

In the first stage of the study, the child records that were audited were existing samples. All information and data used to establish findings were therefore anonymised. The local Patient Advisory Liaison Service and Caldicott guardian were actively involved in ensuring that procedures were carried out appropriately.

All focus group participants were sent an invitation letter, information leaflet and invited to participate, and written consent was requested. Participants were informed that if the information given contravened their professional code of conduct, the researcher would be obliged to inform their line manager. During the study, information gained was not detrimental to

Box 1. Topic guide for focus group discussions

Question: In order to safeguard children, can you tell me your views on how and why we use ED child records?

Prompts:

- Bring out the experiences they have had when using the records
- Reasons for using child records
- Knowledge about the use of these records
- Do you feel there are issues or concerns that require further discussion or have not yet been addressed?

Closure – explain what happens now – and thank you.

professional practice, did not affect the wellbeing of children, and was treated in confidence. The rights of the individuals, the multiprofessional ED team and LOCP group members were considered throughout the study.

Data analysis

Data analysis was guided by the research design. The documentary data from the audit of child records were categorised into themes. The PCT audit department provided assistance in the analysis of data from this stage of the study. Both of the focus group discussions had been transcribed verbatim, and each transcription was read several times by the researcher. Significant statements were then extracted from the transcripts. Following this, the results were shared with the participants for validation - this was done informally and as an on-going process as the data were collected.

The results from all three stages of the study were then organised into theme clusters, and eventually into theme categories. This was in order to provide an in-depth and detailed understanding of the use of the records. The method of qualitative analysis described by Colaizzi[8] was used to provide a rich description of the essential structure of the phenomenon. Colaizzi[8] developed this approach from the Duquesne (Husserlian) school of phenomenology, and his method is frequently used to understand the lived experience. The analysis of the study data was supported by the use of NVivo qualitative data analysis software.

Results

The methods used in the audit and two focus groups generated a rich source of qualitative data, which provided an in-depth and detailed understanding of the use of child records in the ED.

Audit of child records

A total of 2646 children were recorded as having attended the ED department between 1 May and 5 November 2007. Of their records, 14.3% (n=378) were audited. In 73 (19.3%) of these records, a cause for concern was identified by the auditor-researcher (see Tables 1 and 2).

Key finding

Although a cause for concern was picked up by the auditor-researcher in 73 (19.3%) records out of the 378 that were audited, the ED staff had not highlighted this cause for concern in 47 of these child records. This means that 47 of these causes for concern were identified by the PLHV.

Perhaps, in a clinical area such as the ED some healthcare staff are not always aware of the predisposing factors, signs and indicators of a cause for concern. Not every member of the ED staff may have the same knowledge and experience. Therefore, although concerns would come from the ED staff who assess the child, it would be a matter of professional judgement whether some form of action was warranted. The possibility existed that the process of using professional judgement may be influenced by informal or latent functions associated with record keeping within the environment (such as diverting responsibility on to others, avoiding blame, demonstrating status and authority), which could impede the primary function of investigating possible abuse or children at risk.

Standard 5 of the NSF[4] states that as a matter of good practice, staff at all levels need to understand their roles and responsibilities related to the safeguarding of children and young people and promotion of their welfare. It also states that they should be trained appropriately to undertake these responsibilities effectively. Consequently, if the professional who actually attends to the child highlights a cause for concern, not only does this ensure that there is an efficient, accurate handover that avoids misunderstandings and discrepancies, but crucially that parents are aware that a referral has been made. In addition, the professional who actually attends the child has the full picture about the demeanour, distress and any other non-medical indications of the child and family.

Other findings

Where the record was complete and/or a cause for concern was identified on the records, 67 had follow-up appointments or referrals to specialist practitioners or other agencies recorded and six did not. Of the 67 cases where referrals were deemed necessary, the PLHV and not the ED staff made 47 of these. The audit results also indicated certain failures in compliance to record-keeping and/or ED procedures to reflect best evidence-based safe practice, such as record-keeping policies and procedures for safeguarding children.

Focus groups

The central themes that reflected the focus group discussions in stages two and three of the study were communication and documentation.

Non-ED staff

Participants identified the importance of effective communication. Primarily, they considered that ED records were a good tool for communication. However, effective communication relates to documentation. They therefore highlighted the fact that written documentation should incorporate a comprehensive history, since this information could alert a clinician to possible risk factors that are likely to affect the welfare of the child. They emphasised that any shortcomings in documentation may create multiple difficulties for another agency or professional to which the child is referred, as inaccurate accounts may lead to failure to safeguard a child:

I thought it was important to have a discussion with the other health visitors at my clinic about this topic after I received the information and had decided to participate in the focus group. So I am not only expressing my own views, but also those of my colleagues. We all feel [the ED records] are a good thing, but there are times when we have difficulties in understanding the illegible handwriting.

Table 1. Summary of details included in records

Details in records	Yes	No
Date and time seen by professional	66	7
Date and time of incident or accident	5	68
Ethnic group	2	71
Is there legible history?	27	46
Is the record complete?	7	66
Is a cause for concern identified on the record?	24	49

They are useful but they do not include an action plan or care plan (health visitor).
I have spoken to a few other members of the team about the forms we receive from [the ED]. On the whole, I think the information is good. However, unable to distinguish if anything put in place for child following attendance... many children attend intoxicated in one area – may lead to health promotion activity. Follow up mainly termination of pregnancies, overdoses, intoxication, alcohol or drugs (school health advisor).
Forms not received, page at back not completed, which would be most appropriate to complete [with the] box relating to concerns. I have spoken to the other GPs... most reported [they] do not receive these records. All they receive is a brief letter which does not give enough information. We feel it would be helpful to receive these records. It would be helpful if the page at the back is completed with the most appropriate information – box relating to concerns. Most reports mainly only seen from the front page, not seen page at the back (GP).

Every child matters[1] and the Laming reports[2,6] promote the improvement of communication among staff and services involved in safeguarding children.

ED staff

The participants focused their attention on the issue of incomplete documentation. They were concerned that the existing records did not provide a format to enable staff to record comprehensive information:
I think we need a little bit more information on the front of the records – a tick-box would help staff to remember what needs to be included... We should, I think, have the GP and health visitor down as well, things like that. The tick-box thing maybe would help staff. A tick-box would help staff. This could be used for adults as well as children (ED sister).
Some information is so inaccurate you really need to go and dig that card out (nurse 3).

Key points

- Child records have the potential to be a good tool for communication
- Written documentation can be unclear, insufficiently focused on the child, illegible and incomplete
- Risk factors are not always recognised
- Existing written records may not provide a format that enables staff to record information comprehensively

Something that concerns me on the front of the records is that we have 'accompanied by' and the usual – we need to know who that person is. A name and the relationship to the child as well. Making sure that the person who is with the child, especially if they have another name, has the responsibility to authorise that treatment. We need to know who this person is before we treat (named doctor).

The NSF[4] and *Working together to safeguard children*[5] promote good documentation as an essential underpinning to good child protection practice.

Service response and implications

The findings were shared by making presentations at ED team meetings and at meetings of the LOCP group. The participants in this research and the immediate stakeholders stated that they believed the results to be useful. They offered positive comments and support for the study, and this in turn has generated warrants for action. Subsequently, the immediate stakeholders agreed that ED children's records would be redesigned, with a clearly identified single page dedicated to addressing safeguarding issues.

The existing research highlights that written records in their present form do not provide a format that enables staff to record information comprehensively, and this limits the ability of the professional to provide information to safeguard children. The most important hazard of poor communication between professionals is a risk to the children.[1,4] Shortcomings begin from the moment a child's history is documented, therefore inaccurate accounts can lead to a child remaining unsafe or wrongful action being taken,[2,5,6] as happened in the case of Peter Connelly ('Baby P') in 2007. Subsequently, good records are at the heart of professional practice and effective communication.[1,2,5]

Conclusion

The goal of this small-scale qualitative study was to acquire a better understanding of the use of ED records. This study was part-fulfilment of a PhD thesis – a more in-depth analysis of the findings is required and is still in progress. Although paperless records will be utilised in the very near future, improving written records is essential in leading the way for effective information sharing, in order to help and safeguard children such as Peter Connelly. It is hoped that the publication of the findings of this study will stimulate further research on the topic.

Acknowledgments

The author would like to thank her PhD supervisors Andy Stevens and Bill Scaife at Anglia Ruskin University, and all of the study participants for their support.

Table 2. Record data indicating cause for concern to auditor

Nature of risks	Number of causes for concern
Delay in presenting for treatment	5
Frequent attendances	27
Injury in non- mobile child	5
Children who needed support from other services	52
Genital injury problem	1

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P A E N ED-09-000178-1

Hospitals NHS
NHS Foundation Trust

Location: Majors Waiting	A&E No:	Adm. Date & Time:
Consultant:	Hospital No:	No. of A&E attendances: 1
Receptionist:	NHS No:	Mode of Arrival: Private Transport

PERSONAL DETAILS	NEXT OF KIN	
Title: Sex: Female	Name:	
Surname:	Relationship: brother	
Forename:	NOK Address:	
DOB:		
Perm Address:		
	Tel No:	Mobile:
	PRACTITIONER DETAILS	
Tel No: Mobile:	GP Name:	
Contact Address:	Address:	
Tel No: Mobile:	Tel No:	GP No:
1st Language: English	Social Worker:	
Ethnic Group:	INFECTION / SPECIAL RISKS	
Religion: Church of England	Previous MRSA Carrier:	
Occupation (or previous): student	Swab Date:	Site:
Registered Disability:	MRSA screen required?	
ALLERGIES	Swab Date:	Result:
	Site:	
	Other Risks:	

ATTENDANCE & INITIAL ASSESSMENT DETAILS			INVESTIGATIONS
Presenting Complaint:	Time Since Incident: 6 - 12 hours		Urine:
Discriminator:	Triage Category:		HCG:
Notes:		Smoker?	ECG:
		Alcohol?	FBC:
		SG?	U&E:
		IMMS?	G&S:
			Coag:
			Cultures:
			X Ray:

LIMITATION OF LIABILITY	TREATMENTS
Notice is hereby given that ; University Hospitals NHS Foundation Trust accepts no responsibility for the loss of, or damage to personal property of any kind, including money, in whatever way the loss or damage may occur, unless a copy of the valuables form gives evidence that items have been handed in for safe keeping. I have been informed of ; University Hospitals NHS Foundation Trust limitations of liability and that the Trust cannot accept responsibility for any belongings not handed over for safe keeping. Any items retained by me are kept at my own risk.	Analgesia Offered:
	Rings Removed:
	Sling Applied:

Date:	Signature:	Print Name:	Last ate and drank:

SAFEGUARDING			
Name: **No. of A&E Attendances:** **Age:** **Arrival Time**			
SPECIAL FACTORS OR CONCERNS			
Concern	Yes	No	Comments:
Delay in presentation?			
History inconsistent with injury?			
Frequent attendance?			
Injury in a non-mobile child?			
Any Genital injury/problem?			
Other concerns?			
Action			Outcome:
Discussed with senior Dr/Nurse			
Check child protection register			
Discussed with paediatrician			
Health Visitor – discussion/referral			
Discussion with child protection unit			
Referral to CFCS			Signature: Date & Time:

Date & Time	Clinical Notes	Signature & Stamp

Appendix 37 Letter from Liaison/Child Protection Co-ordinators - Swansea

Liaison Child Protection Co-ordinators
Morriston Hospital
Room 7
Old Personnel Building
Morriston Hospital, Swansea, SA6 6NL

e-mail: **@swansea-tr.wales.nhs.uk**

27th October 2006

Joyce Forge
Paediatric Liaison Specialist Health Visitor
Care Trust, Essex.

Dear Ms Forge

I read with great interest the article you wrote for the Community Practitioner magazine on Improving Services for Children - Sharing Accident and Emergency Records and am very impressed with the work you have done. Information sharing for us as paediatric Health Visitors from the records in A and E for children is a minefield and your poster explains very clearly not only our role but also who we are likely to share information with and why.

We currently display written information to parents about the use of information but your poster captures all the information in a much better format. Would you have any objections to us displaying this poster in our Accident and Emergency Unit at Morriston Hospital, Swansea. I look forward to your reply,

S

Liaison/Child Protection Co-ordinator, Morriston Hospital, Swansea

Appendix 38 Disseminating information

Anglia Ruskin University

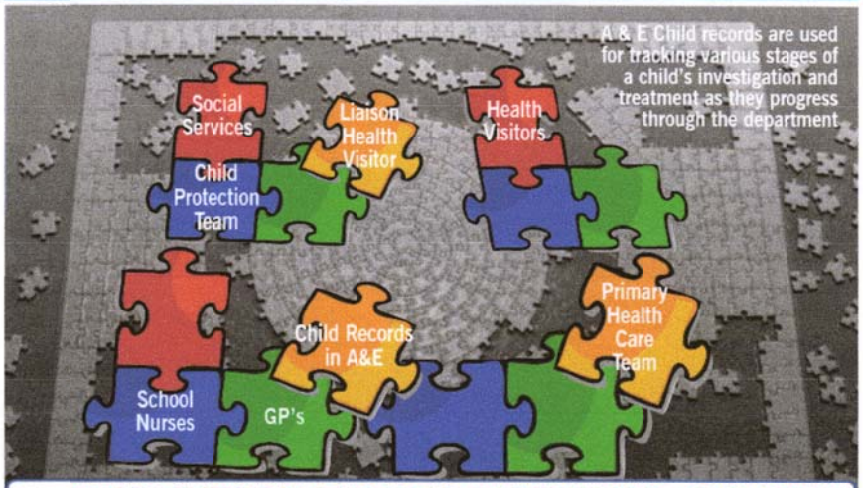
Faculty of Health & Social Care

Cambridge & Chelmsford

Safeguarding Children at Risk:
The role of shared records in accident & emergency sevices

Joyce Forge

joyce.forge@student.anglia.ac.uk



SHARING INFORMATION TO SAFEGUARD CHILDREN

Research question:
Do staff in Accident and Emergency and other agencies perceive the use of child records (0-16 years) to be a vehicle for the safeguard of children considered to be at risk?

Background
- A key factor in the failure to safeguard and promote the welfare of children has been a failure to record information.
- Too often children's A&E records are used inappropriately.

Emerging findings:
- Shared records are a good tool for communication.
- Risk factors are not always identified or recognised in child records.
- Documentation can be unclear, not sufficiently child focused, illegible or incomplete.

Methodology:
- A case study methodology is used as the study seeks to uncover the story of why and how A&E child records are used.
- The study is carried out in three stages: (1) Analysis of a purposive sample of A&E child records age from 0-16 years; (2) a focus group with 10-12 members of A&E staff at the case study site; and (3) a focus group of 10-12 members of the local operational child protection group (outside agencies).
- Ethical approval was granted in 2007.

Acknowledgements
Thanks to my supervisory team: Professor Diane DeBell and Dr. Tina Moules. Thanks also to my sponsor: South West Essex PCT

www.anglia.ac.uk

NHS
Primary Care Trust

Fax:
E-Mail:

Our ref:

Date: 16th April 2008

Joyce Forge
Paediatric Liaison Health Visitor

Hospital
( )

Dear Joyce

Re: Annual Research Conference "Celebrating Success"

I am writing to congratulate you on receiving an award from Anglia Ruskin University of First Prize for your poster "Safeguarding Children at Risk".

Well done on receiving this acknowledgement for your excellent work on this project and a personal "Thank You" from me for your continued dedication and hard work in your "day job".

Best regards.

Managing Director

POSITIVE ABOUT DISABLED PEOPLE

APO Managing Director: **APO Chair:**
PCT Chief Executive: **PCT Interim Chair:**
Registered Head Office:
Telephone:
www

NHS
Primary Care Trust

Date: 21st April 2008

Tel:
Fax:

Our Ref: Forge

Ms Joyce Forge
Paediatric Liaison Health Visitor

Hospital
Drop

Dear Joyce

Annual Research Conference "Celebrating Success"

May I add my sincere congratulations on your award, which I was delighted to hear about and at least a little public recognition for your hard work and commitment.

A very well deserved reward.

Yours sincerely

Barbara

Director of Quality and Nursing

Chief Executive: **Chair:**
Registered Head Office:
Telephone:

POSITIVE ABOUT DISABLED PEOPLE

NEWS

▲ *Prize-winning research students with (far left, back row) Professor Caroline Strange, Director, Research Support and Knowledge Transfer Training, and (far right, front row) Professor Alan Sibbald, Deputy Vice Chancellor.*

Second Annual Research Student Conference

Research, Development and Commercial Services held the second Annual Research Student Conference on 2 April at the Cambridge campus. It was a great success. Participants reported how interesting and informative the conference was, as well as providing an ideal opportunity to meet and network with other research students. The conference was aimed at postgraduate research students, their supervisors and research administrators, but was open to everyone at Anglia Ruskin.

Prior to the conference, research students were asked to submit abstracts for poster and paper presentations. We are very grateful to Media Production, who consulted with students and produced the final versions of the posters. In all, there were 17 posters and 19 paper presentations, covering a range of different subject areas.

Professor Alan Sibbald opened the conference. The key presentation was 'Examining the Thesis: The Examiner's Perspective', which was facilitated by Professor Graham Badley, Professor Sarah Annes Brown, Dr Robert Willis and Dr Silvea Cirstea.

There were two opportunities for students to present papers with five parallel sessions on each occasion. One of the presenters travelled from Israel especially for the conference. The posters were displayed in The Street, Helmore building. After lunch, students presenting posters were available to discuss these and answer questions about their research.

Additionally, five workshops were run in parallel. These were:

- Maintaining Momentum in your Research – Dr Valerie Shephard
- Structured Literature Reviews – Dr Andy Armitage and Dr Diane Keeble-Allen
- Publishing your Perishing Research: What Editors Really, Really Want – Professor Graham Badley
- Thinking about your Viva – Dr Robert Willis
- Networking for a Successful Career – Gill Betmead

Prior to the day, a panel judged the best abstract and best posters. During the conference, two members of staff sat in on each of the paper presentations by research students to judge them. All the judges subsequently met to decide on the best papers.

The day ended with the presentation of prizes for the best abstract, posters and papers by Professor Alan Sibbald. The winners were:

Best abstract
Peter Brown, Science and Technology – The Spread of an Invasive Ladybird, *Harmonia axyridis*, in Europe

Prizes for posters
First prize
Joyce Forge, Health and Social Care – Safeguarding Children at Risk: The Role of Shared Records in Accident and Emergency Services

Second prize
Francesco Agnello, Science and Technology – Automatic and Electrophysiological Data Fusion for Real Time Myocardial Ischemia Detection in Coronary Patients

Joint third prize
Blaise Martay, Science and Technology – Comparing the Conservation Status of Old and New Fenland Using Ground Beetles; and, Vineela Varikuti, Science and Technology – The Importance of Letter Spacing in Vision Charts

Prizes for the five best papers
Steven Abbott, Science and Technology – Early Experimental Results of a Novel Data Processing System to Account for Variability in Phono Arthrometry

Stephanie Crass, Science and Technology – Classifying Water in Soft Contact Lens Hydrogels: An Investigation Using Infrared Spectroscopy

Andreea Fulga, Health and Social Care – The Investigation of Stakeholder's Perspectives of Major Changes in Public Dental Care in England and Romania 1990–2006

Paulette Luff, Education – Observing Observation: a Participant's Insights

Ramin Rahmani, Science and Technology – An Artificial Intelligence Approach to Optimise Laser Textured Surfaces with the Applicability in Car Engines

Joyce features in Community Practitioner

Joyce Forge, specialist health visitor and paediatric liaison at Community Services, has been busy sharing the findings of her PhD research on safeguarding children with the readers of Community Practitioner magazine.

The article, which can be found in the January edition on pages 16 to 19, details the findings of a seven month study into how emergency department child records are used by health and social care professionals.

Dignity in care

Dignity acti… day, held on … February was a … Julie Morton and Freda … Pharmacist a number … Thursday 2… great succe…

The dignity … supports th… of Health's … campaign. … end intoler… indignity a… in health a… services by getting both staff and the public talking about what dignity in care means and inspiring them to take action.

… to promote dign… in care visit www.dignityincare.org.uk